

**The Psychoanalytic Study
of the Child**

VOLUME V

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PSYCHOANALYSIS AND DEVELOPMENTAL PSYCHOLOGY¹

By HEINZ HARTMANN, M D (New York)

There is some thematic continuity between our previous Panel Discussion on "Theories of Psychoanalysis," held in Montreal one year ago, and the papers we shall hear today. In choosing as our topic Psychoanalysis and Developmental Psychology, we wanted to emphasize the growing importance of this aspect of psychoanalysis, and also to give a fuller account of thoughts and experiences that were presented at last year's Convention. Some aspects of what will be said today will no doubt overlap with the field covered by the recent meeting in Stockbridge, at which Anna Freud and others discussed the present state of analytic child psychology. However, given the incompleteness of our knowledge in this field, and the tentative nature of our propositions, a repeated working through of the rather complex problems involved will, I think, be all for the good.

As to my own contribution, I want to present a few considerations only, which might prove helpful as an introduction to the topic of our Panel. I am fully aware of its unsystematic character. Although the principles of what analysis can contribute to developmental psychology have never been systematically stated, I think that we may have reached a point at which an attempt would be feasible and fruitful. But I am by no means prepared to undertake such a presentation, at least not here and now.

Years ago Freud complained that the direct observations of child psychologists are frequently questionable because they describe phenomena not really understood in their relationships and in their dynamic impact—while, on the other hand, the conclusions about childhood which we reach on the basis of analysis with adults have the disadvantage that we gain them through a complicated system of reconstructions only, and through many detours of thought. This gap could be closed in part, but not completely, by child analysis. Therefore the combination of the direct longitudinal observation from early childhood on, with the reconstructive data furnished by analysis, is of paramount importance. But this two-fold approach has been made possible only as a consequence of systematic analytic work on ego psychology, or of structural psychology in gen-

¹ Contribution to the Panel of the same title held at the Meeting of the American Psychoanalytic Association in Detroit on April 29, 1950.

eral, which provided us with the indispensable frame of reference and with the necessary tools for a fruitful collaboration.

It is a memorable fact that Freud, using reconstructive methods, could ascertain not only experiences of early childhood, typical or atypical, but also typical maturational sequences that had escaped the methods of direct observation, as in the case of the stages of libidinous development. Still it remains true that to every technique of observation certain groups of facts and connections are more easily accessible than others. Of course the methods are being adjusted to the objects, but what I have in mind here is rather the fact that the use of every method implies a selection of data, and that the data are being centered in different ways, depending on our approach. In the case of analysis, what its method has made accessible to observation, and in many instances made visible for the first time, is centered in the sphere of conflict. Although there actually is constant interaction between conflictual and non-conflictual development, so far less light has been shed by analysts on the non-conflictual sphere.

In stating that the analytic "method" opens the way to the developmentally central position of conflict, I should actually have referred to three factors, not only to one, although the three are obviously interrelated. There is, besides the method, in the narrower sense in which we use the word, also the analytic situation, which owes many of its possibilities to the fact that, despite its strict circumscription, it is essentially a real life situation, it is meaningful also as part of the therapeutic process. The third contributing factor is the attitude of the analyst toward the psychological data he uncovers. Thus I have discussed more in detail elsewhere, but in the context of today's discussion I may limit myself to a few remarks only. I am thinking particularly of the correction of what in other fields is called the "personal equation," that is, of the correction of those potential handicaps of observation traceable to the personality of the observer and to his interference in the field. Because the analyst is not only an observer of the field, but also an actor in it, it has been said that analysis is actually a kind of "technosophy," and that this contradicts its claims to also being a regular science. It is true that analysis introduces new factors—factors neglected by other methods of observation, not only into the analytical situation, but also into the direct observation of children—and that, with us, the field of observation in this case is defined, not only by the child's behavior but also includes conscious and unconscious attitudes of the observer and the interaction of both groups of factors. But all these factors are subject to constant psychological scrutiny. By acting in the field and studying action and reaction, data are made accessible that had not been accessible to other methods, and we come to

understand the personal relationship which is at the basis of the observational situation. This is also what Dr. Kris pointed to when he spoke in Stockbridge about 'action research' and 'pure research'. Actually in carefully studying the interaction in the field of the observer with his object, analysts have done radically and in a consistent way something that has become ever more important in some disciplines of natural science, too, or for that matter, of social science.

All three of the factors which I mentioned are characteristics of analysis, but absent in other psychological methods. Direct observation by non-analysts of necessity missed many central developmental positions and trends, because it tends to scotomize the child's instinctual and other conflicts, and particularly their unconscious aspects. What often appears as a detail hardly understood and seemingly negligible, may become all important if viewed from the angle of analysis. A great number of childhood situations of incisive significance for the formation of adult personality have a low probability of direct manifestation, if I may borrow a term from genetics, but in such cases analytic insight, the bulk of which is based on reconstruction, enables us to gain an understanding of the continuity of development. Gradients of growth, as established by child psychologists, mainly dealt with the maturational aspects and gave only part of the picture. The mutual checking of the data revealed by one method against those revealed by the other one promises a more complete insight. Theories about early developmental stages have to be built on data of both reconstruction and direct observation.

It is obvious that we conceive the problem not as one to be approached by just adding reconstructive data to data of direct observation, but rather by a meaningful interpenetration. How a conflict hardly accessible to the so-called objective methods may influence the intellectual or motor achievements of a child—how, on the other hand, maturational sequences underlying the intellectual or motor achievement may bear on a child's ego development, and his ways of solving conflicts, can best be seen on the basis of such a comparative study. There is another important aspect to this. Such studies will of necessity lead to a growing awareness of the sign or signal function behavior details may have for the observer, that is to a better or more systematic understanding of how data of direct observation can be used as indicators of structurally central and partly unconscious developments—in a sense that by far transcends the possibilities of sign interpretation accessible to the various methods of testing. You realize how decisive this may become also for analytically planned preventive measures.

To what I said about the selective nature of every approach, I may now remind you of the fact that there is also a temporary limitation to the

use of the analytic method. It does not provide us with data (memories) about the undifferentiated phase during which the demarcation line between the ego and the id, and between the self and the objects, are drawn, and it gives no direct information at least up to the end of the preverbal stage. Direct observation here helps first of all to discard hypotheses which are not consistent with behavioral data. But it is equally relevant in giving positive cues for the formulation of our developmental propositions.

Again, the importance of this factor has to do with the genetic character of so many analytic propositions. Analytic concepts, in striking contradistinction to those of most other branches of psychology, are principally genetic in nature⁽⁵⁾. They encompass mental phenomena which have a common origin rather than being merely descriptive. For instance, our typologies, oral character, anal character, etc., are defined by the genetic predominance of certain factors but may contain elements that are contradictory in a descriptive sense—greediness and wastefulness, sadism and pity, and so forth. This approach proves superior because it allows to evaluate the dynamic potentialities of such characteristics, and thus to make predictions more reliable.

It is this genetic nature of analytic thinking that finds itself handicapped by the temporary limitations set by the analytic method and which challenges us to extend our insight beyond these borders. This extension can proceed along the lines of extrapolation of analytic findings to the preverbal stage, in describing it in terms of basic concepts (Glover, 4) derived from the study of later stages of development, or, it can be done by direct but analytically informed observation. Both ways are necessary. Because of what I said, the study of the preverbal stage is a testing ground for many of our most general assumptions, and also a prerequisite for theoretical advances in a variety of aspects. This is the reason why I thought that in the framework of our discussions on theories of analysis a special place should be assigned to its interrelations with developmental psychology.

You see from what I said what significant position we attribute today to this comparatively recent direction of research in analysis. We come to the conclusion that psychoanalytic psychology is not limited to what can be gained through the use of the psychoanalytic method, and, second, that the meaning we give to analysis transcends its psychiatric aspects. Analysis is also, and has always been in Freud's work, general psychology. Freud's aim, expressed as early as in the Nineties, in material recently published, was to get insight into the entirety of mental functions and not only in the pathology of neuroses. That the study of normal behavior is an essential element of analysis appears particularly clearly in that aspect.

which we are discussing today. If a comparison to physical medicine is permissible. The narrower concept of analysis, which is the explanation of nervous diseases, gives you pathology and clinic without 'physiology,' or with physiology only as a by-product. The more comprehensive one adds 'physiology' with all the implications this is bound to have for our insight into both normal and pathological behavior. Strictly speaking, how sound our general statements and our predictions can be depends in the last resort here, as in other fields, on how far a general theory can be developed, and this, in the case of analysis, can only mean a theory dealing with normal as well as pathological development.

The description of several typical stages of libidinous development, and of their relations to aims, attitudes toward objects, modes of action, etc., was Freud's first approach to finding a frame of reference for a great variety of data on growth as well as development—after a short, rather "environmentalist" phase, in which Freud had considerably overemphasized the generality and developmental significance of actual seduction of children by adults. He was able to describe individual deviations in their relations to typical sequences. These stages depend to a certain extent on physiological growth, Freud mentions the development of the teeth, or of the anal sphincter muscle, as cases in point. However, while representing steps in maturation, they also show some degree of plasticity vis à vis environmental influences, as all *anlage* factors do. And beyond this the meaning of these biological sequences for the sphere of object relations and the importance of object relations in the biological context—that is, the mutual influence of inner and outer stimuli—have held a central position in analysis from the very first.

What we imply in speaking of these phases is actually not always really limited to libidinous positions and their derivatives or to their interactions with the objects or other environmental factors. We are aware that one cannot describe cross sections of development in terms of the inner and outer vicissitudes of the sexual drives only. It has become relevant also to describe them as to the involvements of another partly independent variable, that is, the vicissitudes of the aggressive drives. This already constitutes a material broadening and differentiation of the developmental frame of reference we use. A further step was made possible by a more detailed and more systematic study of the ego. And again, what we find here is the closest interaction with object relations while the development of object relations is codetermined by ego development, the former is also one of the main factors that determine the latter. Much of what will be discussed today refers to the impact of the advance in ego psychology on our insight into growth and development. Actually, the new level of ego psychology has proved decisive for the analysts' renewed in

terest in problems of developmental psychology and for the possibility to correlate more systematically reconstructive data with data of direct observation—and vis-à-vis questions of a practical nature, like prevention or education, it proved able to overcome certain limitations inherent in the earlier approach

Ego development, like libidinous development, is partly based on processes of maturation. And of the ego aspect, too, some of us are agreed that we have to consider it as a partly primary, independent variable, not entirely traceable to the interaction of drives and environment, also that it partly can become independent from the drives in a secondary way. That is what I mean by the terms primary and secondary autonomy in ego development. The secondary autonomy of functions of the ego has a bearing on the stability of its developmental acquisitions—a problem that I cannot discuss in this context. The point I want to make here is that the ego as well as the two primary drives appear to be partly independent variables. But while we may, or even must, isolate one or the other aspect for purposes of research or of presentation, we shall not forget that only all these aspects together can give a picture of an individual's development as we see it in analysis.

Thus, an outline of comparative studies, using both reconstructive data and data of direct observation, may in part be centered in the typical phases of growth and development so familiar to us from psychoanalytic clinic. Certain principles of the genetic psychology of analysis can be particularly well demonstrated in studying Freud's conception of those phases, some of which I shall discuss later. But that outline must also embrace the structural aspect, the development of the mental systems, and such a comparative study may even prove especially fruitful with respect to the preliminary stages of structure formation.

Among the functions of the ego most systematically studied in analysis as to their relations to the drives and to reality, are no doubt the mechanisms of defense⁽²⁾. Still, certain aspects of their psychology confront us with unsolved problems. A chronology of defense mechanism has been attempted, but so far only its bare outlines are visible and we know little about the factors which determine the individual choice of defense methods. Here I only want to point to the possibility of approaching these problems by observing in children such primitive functions of the autonomous ego which we may consider the first developmental elements of what later will be used in the process of defense. I may mention what Freud calls the "protective barrier against stimuli," or the various functions of inhibition and postponement of discharge we find even before the ego as a definite system has evolved. There may well be a correlation between observable individual differences in such primary factors and later defense

were designated by Mrs Rank as "fragmented ego," and studied in their interaction with object relations(7) We describe such deviations in relation to what we know about typical sequences To what I said before about developmental phases in general, I may add here that what we consider the crucial phases of maturation coincides, as a rule, to a large extent also with the crucial phases as viewed from the angle of environmental influence³ For the case of libido development, the crucial anal, or the crucial phallic phase has a maturational aspect, but is equally defined by the prohibitions and demands of the environment coinciding with it The same is true of the crucial steps in ego development. The average interactions of the child's growth and development, of the psychological characteristics of the relevant figures of his environment, and of the cultural equipment they use in dealing with the child's needs, result in the features typical of the phases in question, the concept of the "phase" here being used in the broader sense I mentioned before They are the outgrowth of a variety of developmental trends, of their chronology and their intensity, which cross one another on the average at a given time and in a specific way, and they have to be described as to all these aspects Their sequence, found by Freud on the basis of reconstruction, we can today take for granted, also what he said about their regular overlapping, and about the clearly traceable impact of earlier on later phases They are indispensable for genetic research, as an average and as a model Their simplifying interpretation, however, shifting the accent too exclusively either on maturation or on object relation, or on any other single one of the factors I mentioned, gives a one sided picture of development. Such seems to me to be the case in Melanie Klein's overemphasizing of the so-called biological factor, or, in the opposite overemphasis of culturalism

However, every one of these factors is variable, although not all to the same extent, and deviations in the timing or shaping of the typical phases may result. We should not be too surprised if features we are used to consider as characteristics of a certain phase may occasionally appear earlier; that is, before the main elements of the phase to which we are used to relate these features have become dominant. Thus phenomena may make a precocious appearance, which, as a rule, would be reserved to the influence of the phase specific conflicts This may be the case if some aspects of the ego have precociously developed because of some factors in the autonomous sphere, because of early and intense identifications, because of an atypical development of the body-ego, or because of a number of other reasons The result as to the feature in question may

³ See also E. Erikson(1)

be like what we find in other cases as the outgrowth of later maturational or environmental sequences. Reaction formations like orderliness or cleanliness, displacements, generalized attitudes, which we are accustomed to find correlated with the anal phase, may then appear before problems of anality have come to dominate the child's life. Empirical evidence in this field is unfortunately scarce so far, but some observations seem to suggest this interpretation. What I just said, as well as what I said previously about the preliminary stages of defense, is meant as an appeal to observation—I think it should be accessible to direct verification. The tools analytic theory provide us with are not only a reliable key to reconstruction. I think that, if consistently used, they are well suited to inform developmental research and allow us to indicate the points at which direct observation can be expected to be most fruitful and to give us truly new insights.

The phase concept as just outlined contains one fundamental approach of analysis to child psychology. Another one is the principle of phase specificity. Obviously we find phallic experiences also on the oral, and oral experiences also on the phallic level. But we see in analysis, quite generally that the importance of factors of any kind which affect development depends to a large extent on the specific phase in which they occur. This, as you know, is also one general principle of developmental physiology or embryology. Here we find that there is a critical period for every experimental interference.

The reaction basis at a given level has also an historical aspect. It is also determined by previous growth and development. To remind you of just one familiar example: the situations that provoke anxiety, and its effects, are specific of developmental stages; still, the disposition to anxiety at any given level is also historically determined. This complexity, though well known, might occasionally have created some confusion in our thinking on genetic causation, and more specifically on pathogeny. We cannot do away with that complexity, but may try to clarify at least one point. For instance, the pathogenic vulnerability, *vis à vis* inner or outer stimuli, we see on a certain level, may find its expression in a way which is specific of this level, even though this vulnerability is definitely traceable to the antecedents—that is to what we know about the factors of growth or environment which marked the earlier phases of an individual's development. We realize how often specific phallic castration fear in the boy is determined by his oral and anal history. On the other hand, phallic castration fear may be predominantly due to factors of growth or environment specific of the phase in which it occurs. Thus while the determi-

be like what we find in other cases as the outgrowth of later maturational or environmental sequences. Reaction formations, like orderliness or cleanliness, displacements, generalized attitudes, which we are accustomed to find correlated with the anal phase, may then appear before problems of anality have come to dominate the child's life. Empirical evidence in this field is unfortunately scarce so far, but some observations seem to suggest this interpretation. What I just said, as well as what I said previously about the preliminary stages of defense, is meant as an appeal to observation—I think it should be accessible to direct verification. The tools analytic theory provide us with are not only a reliable key to reconstruction, I think that, if consistently used, they are well suited to inform developmental research, and allow us to indicate the points at which direct observation can be expected to be most fruitful and to give us truly new insights.

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nants of vulnerability on a given phase may differ, its symptomatic or other expressions may still be very much alike

It appears desirable to note clearly the difference between these two possibilities between the case in which phase-specific vulnerability (and its eventual expression in specific symptoms) is mainly determined by what happened in earlier stages—and between the case in which both the vulnerability in question and its main determinants are specific of the phase in which they occur. This may help us to distinguish more clearly what are the specific features of a given phase from what its genetic determinants are, it may help us to differentiate more clearly the element of genetic continuity from the element of phase-specificity. It also should prevent us from describing what is actually a specific disposition of the later phase as characteristics of its genetic antecedents, as is widely done in some analytic writings, the interpretation of very early object relations in terms of specific features of the oedipal phase, or of early prohibiting functions of the ego in terms specific of the superego being cases in point.

What I said about phase specificity, from the point of view of vulnerability and potential pathological development, is equally true of positive influences on growth and development, and of potentially normal development. There are specific optimal phases for every step in adjustment, integration, overcoming conflicts, and so on. All measures of demand and prohibition, of child rearing, training, and education, and consequently also of mental prophylaxis, have in their timing and dosage to be oriented on phase specificity and its genetic determinants. Anna Freud has clearly stated the problem. This orientation can profit greatly from utilizing data of direct observation. Here we meet again the question of the sign function of behavioral data. It points to the necessity of greater refinement in the use of early developmental data as indicators of actual or potential conflict, and, which is not the same, of actual or potential pathology. The greatest practical importance of what we are discussing today lies, no doubt, in the field of prevention.

The discussion even of only the few points I chose for my introduction tends to evidence the complexity of developmental problems as we see them, and also the complexity of our concept formation, which is not arbitrary but in direct relation with the former. I want to mention that, in reaction to our working with many variables and with complicated causal relations we find today in the periphery of analysis, as in certain trends in child psychology, or, for that matter, in anthropology, a growing number of rash generalizations and simplifying propositions. Out of that great variety of factors which our experience has taught us to consider, one or the other only is selected and made the basis of "new" theories.

Of such simplifications we may speak as of theories by reduction. They see one specific phase or one specific measure of infant training as the sole causative factor for a character type or for general lack of adjustment. Or, they see the fact that the mother has not been constantly good to the infant as responsible for all the ills that can befall a human being. That an infant has or has not been nursed according to certain principles is brought into direct and unilinear causal relation with the later personality type, etc. The elements of the proposition are, if you wish, analytical, but the use made of them is certainly not. Do not misunderstand me. All those factors are relevant and may be isolated for certain purposes. However, what our approach shows us about the whole of a person's development is a rather different picture. We see a complex interdependence of a great variety of developmental factors and a branching out of many alternatives on every subsequent developmental stage.

Finally speaking of the purpose and the rationale of our Panels on Theory, may I say that psychoanalysis today has reached a stage on which it should have become obvious that theory must no longer be considered merely as a more or less occasional by-product of the clinic or as an intellectual hobby of some analysts. Though one or another among us may feel that way, Freud most certainly never did. It has become sufficiently clear that clinical work as well as technical work are severely handicapped and bound to stagnate without it. And we shall keep in mind that as I just said, prevention, which might well become more essential than therapy, is directly dependent upon the trends of research under discussion today.

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DEVELOPMENT OF THE BODY EGO ¹

By WILLIE HOFFER, M.D., Ph.D., LRCP (London)

In recent considerations on the genesis of mental structure Hartmann, Kris and Loewenstein(3) advocate a modification of Freud's view on the origin of the ego as expounded by him in *The Ego and the Id*(1) They suggest with the support of impressive arguments that the ego should no longer be considered the result of differentiation from the id, but that both the ego and the id, should be conceived the result of differentiation from an undifferentiated state

Hartmann, Kris and Loewenstein explicitly "refrained from indicating at what point in early infancy the successive steps leading to structural differentiation take place," but they state that the first and most fundamental step leading to it "concerns the ability of the infant to distinguish between the self and the world around him." This agrees with Freud's own thoughts on ego formation according to which "the ego is the part of the id which has been modified by the direct influence of the external world acting through the Pcpt Cs' (Perceptual-Consciousness)

But there is, according to Freud, another differentiating agency which, instead of being tuned to stimulation from outside, responds to stimuli from within the organ system. Under certain conditions instinctual drives not only act on the bodily and mental apparatus but merely by operating within the organism cause changing states of tension or demands and relaxations which are registered within the body in respect to their intensity and perhaps the locality where they arise I mean the very first sensations and the earliest processes of discharge following an excitation Freud spoke of internal perceptions which in contrast to external ones are more fundamental and more elementary

SELF, BODY AND OBJECT

The visual, auditory and olfactory apparatus has a definite relation to our interest in the outer world which in the most primitive language is the "not-self" On it the environmentalists among us concentrate when

1 Contribution to the Panel on "Psychoanalysis and Developmental Psychology" held at the Meeting of the American Psychoanalytic Association in Detroit on April 29 1960

studying early ego functions. In contrast, inner perception seems according to Freud to be related at first to the pleasure-pain series. In other words, the experience of pleasure and of a self emerges in consequence of the relief of pain (relief of stimulation calling for restoration of the previous condition or of the relief of an increase of inner demands). This relief happens in two stages: 1) by an attempted relief due to an inner psychical act, called negative hallucination, 2) by a physical act of discharge which in the first instance we can only interpret as the organism's attempt to rid itself of a surplus stimulation (or inner demand).

Negative hallucination refers to the temporary abolition of a stimulus, inside or outside the body, not to the abolition of the mental representation of such stimuli like in repression. Negative hallucination is, therefore, in later life related to the pathological state of derealisation (*Entfremdungsgefühl*) and connotes one of the earliest and most primitive of mental processes.

We feel on firm ground, however, as soon as we think of mental processes which characterize the spread of the feeling of self over the infant's body, in which the self is housed. When the body is seen—after sight has been sufficiently developed—it is perceived like any other object reaching the infant's mind, by the organ of vision. Quite different is the effect of the perceptual experience when the infant touches his body. Here two sensations simultaneously yield an experience, and this may arise very early in life, perhaps even in the intrauterine state. Our own experience when touching the body makes us think of one part of our body, the hand for instance actively approaching another part which passively experiences being touched. There seems no simple justification for assuming that the same happens in early infancy. Coming in touch with its own body elicits two sensations of the same quality and these lead to the distinction between the self and the not-self, between body and what subsequently becomes environment. In consequence this factor contributes to the processes of structural differentiation. Delimitation between the self-body and the outer world, the world where the objects are found, is thus initiated.

THE MOUTH EGO

In psychoanalysis we define the structural entity ego according to its function. In our clinical work they manifest themselves in highly organized and differentiated psychic activities. In childhood and especially in infancy they have a definite physical, bodily connotation.

On another occasion⁽⁴⁾ I have described the difference between a drive (instinct) gratification as such and one interfered with by a func-

tioning ego To summarize it once more there is a striking difference between infants at the age of up to ten weeks as compared with those of twelve to sixteen weeks An infant of four weeks when slightly hungry and waiting to be fed may display some oral activities, accompanied by movements of the head, arms and hands The hands may still be kept in a position resembling the uterine position where the hands were nearest to the mouth(6, 2) While the hand is moving over the face the mouth may get hold of it and finger-sucking will ensue Until a few weeks old it will not make much difference whether the whole hand or one or two fingers slip into the mouth, whether a bottle or a comforter has been offered to the baby The behavior which it displays is (a) motor excitation, most probably due to hunger and influenced by former feeding experiences (searching for the breast) and (b) attempts to relieve the excitation by mouth activities which may lead to finger sucking

Quite different is the behavior observed in a sixteen weeks-old infant. Little is left to chance gratification During the state of expectancy before being fed or after a successful feed the infant may insist on a definite form of oral sucking gratification and the activities leading to this gratification comply with almost all the criteria by which we assess ego functioning

There is

(1) *Genuine Perceptual Activity* The infant of three months sees his hand, focuses on it, follows with his eyes its movements towards the mouth. If the infant's eyes catch another visual stimulus, especially something moving, they may be distracted but will return to the hand which tends towards the mouth In the setting described there is true perception

(2) *Motor Control* The movement of the hand towards the mouth may be achieved only with great difficulty, chance movements are either impossible or the infant counteracts them it tries to aid the hand which has to be sucked When the eyes participate in the control of movement towards the mouth there seems to be a pleasant realization on the side of the space which is within reach of the arms and hands The mouth ego has widened to the space embraced by the arms

(3) *Functioning of Memory* is suggested by the specific mode of gratification which is achieved by finger-sucking Out of a vast free choice of possible positions of the hand and fingers, the infant develops and adheres to a number of sucking patterns involving either his hand and fingers or his mouth or both

(4) *Reality Testing* can be traced by the infant's meticulous choice of what he wishes to introduce into the mouth When he wishes to use the fingers he will reject the spoon or comforter or breast. Some infants display a minor feeding difficulty seldom mentioned by insisting on suck

ing the fingers while being fed. This competition between feeding and finger sucking seems to be a further proof of the infant's knowledge and understanding of mouth and hand in their relation to each other. No such specificity has generally been assumed for the infant's relationship to the nursing mother, the breast or the bottle and no definite individual picture of an "object" seems yet to have been created in the child's mind at that age. It should, however, be possible to put these problems to the test by experimentally investigating the infant's reality testing with regard to objects which do not convey the feeling of self.

(5) *Synthetic Function of the Ego* No definite suggestion about the operating of the synthetic function in early infancy characterizing what I called the "mouth-ego" can be put forward. But this may be merely due to lack of observational evidence or to the nursing mother's activity who at this early stage may make this function unnecessary.

MOUTH EGO AND BODY EGO

With the help of the hand the oral sucking drive undergoes a transformation from an instinctual demand to an ego-controlled activity. In the course of this process the hand, like the mouth, is perceived as part of the self and the differentiation between self and not self is thus carried forward. All these processes have so far been confined to the oral phase of instinct and ego development.²

With the emergence of a real mouth ego the hand acquires the properties of a tool for the execution of needs serving the interests of the self. To give an example: a successful feed will in the first weeks of life be followed by sleep, almost immediately, when the mouth-ego is established. Satiation will be followed by two needs, sucking and sleep, thus the infant will actively introduce his fingers into the mouth, and will concentrate on this activity until it is achieved. Thus it serves the need for sleep as well. There is, we assume, no struggle between the two needs, the gratification of one leads to the gratification of the other. In this way the self has put itself in control of needs: a form of independence and an ability to channel instinctual drives according to earlier experiences.

In consequence, in the oral sadistic phase aggressive impulses are already drawn away from the body and, I assume, directed into oral biting activities which do not affect the self. In short, the self tries to protect itself against its own aggressive feelings—originating in instinctual demands—by directing them through the body organs towards the non self, the outer world. This involves progressive libidinalization of the body, and prepares the way for the integration of the subsequent instinctual stages.

² The administration of the breast or bottle may stimulate formation of object relation at the expense of body-ego formation.

into the ego organization I believe there is continuity of ego development and integrative endeavor at work, in parts very successful

FATE OF AGGRESSION DURING THE DEVELOPMENT OF THE BODY-EGO

Progressive libidization of the infantile body and growth of the body ego can only be assumed if self-destructive drives are either dealt with within the body or diverted elsewhere outside it. The fact that there is an increase of motor activity from the second half of the first year onwards supports the second alternative. It is primarily the pain barrier which protects the infant against his destructive instinct turning against his own self⁽⁵⁾. In addition owing to the nursing activities but also to the mouth-hand relationship the process of libidization of the body rises to the level of self-love. Increase of primary narcissism forms a second protective barrier. This occurs in the oral-sadistic stage characterized by the appearance of the teeth and heightened oral-aggressive stimulation. The infant does not hurt himself because he likes himself so much. This statement does not contradict the concept of erotogenic masochism, but when speaking here of self-destructiveness this should be understood literally. When these steps towards deflection of self-destructiveness fail, damage to oneself by biting, refusal of food and starvation open up the subject of the pathology of the body-ego.

CLINICAL IMPLICATIONS OF THE BODY-EGO

From what has been said of the path of early ego development it seems to me conceivable that, except for the experience of birth, the infant is equipped with the means of achieving equilibrium between his inner needs without necessarily heading towards traumatization. Still, infants may have to pass through and even succumb to most painful states of a traumatic character, in the sense that the quantity of excitation aroused is beyond the infant's ability to master. Three possible sources of traumatization can be visualized.

(1) *Increase of excitation (stimulation)*. As an example I mention the process of teething. This arouses inner perceptual activities with which the self has to deal by means of (a) negative hallucination which will be of short duration (withdrawal of cathexis from the sensation), (b) loss of oral-sucking activity and of appetite, which corresponds to withdrawal of cathexis from the organ and its accustomed activity (extinction of oral-erotic desires), (c) turning inwards of oral aggression not utilized in the feeding process which is refused, (d) attempts at ego control of stimulation by biting the finger or hand with the gums, which are in

fact attempts at integration of pain with the help of the hand, (e) failure of these attempts and cessation of self control expressed in crying and convulsive activities

The solutions found (a e) may become paradigmatic for subsequent states of increased excitation (pathology of the body-ego)

(2) *Inadequacy of the self in dealing with excitation (stimulation)*
The self emerges as a function of the interaction between inner drive (stimulation) and the apparatus (bodily organs like the mouth) through which the drive acts. Sometimes this interaction seems inert, though there are ample signs of the presence of stimulation. The instinctual drive meets a body and a self which respond only slowly. This may mean mere delay of ego development which need not be of any clinical significance, but it may also mean that ego development has been retarded to such a degree that it has fallen out of step with the instinctual development. Translated into the teething period it means that while the teeth break through accompanied by a comparatively enormous increase of oral sadistic stimulation, neither the stomach and intestinal apparatus nor the mouth, tongue and hand have sufficiently achieved the state of body ego maturity which would be needed to master the quantity of oral sadistic excitation, in itself normal.

(3) *Failure of the "Not Self"* By this I mean the defect or excess displayed by the nursing mother, who is called upon to remove what interferes with the quiet growth of the self until it turns to the object as such. From the point of view of the infant's inner economy this failure results either in an increase of excitation or in the self's becoming inadequate for the dealing with normal excitation. Too little milk heightens the demand for abolishing hunger, enough food, enough intake, but inadequate administration does the same. In both conditions the infant will react as if only his inner excitation were raised. His capability of controlling excitation is low, but within its range the self makes use of the body and the apparatus as if it were acting thoughtfully and with foresight.

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NOTES ON THE DEVELOPMENT AND ON SOME CURRENT PROBLEMS OF PSYCHOANALYTIC CHILD PSYCHOLOGY ¹

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The beginnings of psychoanalytic child psychology can be traced back to the period of 1890 to 1900 when clinical observations first suggested to Freud that childhood experiences constitute one of the etiological factors in neurotic symptom formation in the adult. Material made accessible recently shows that from this starting point a set of generalizations arose, which enabled Freud to recognize the potentialities of his whole approach in psychopathology, to establish the relative independence of his findings from neuropsychology in the contemporary meaning of the word and thus fully to realize the scope of his venture. We are justified in saying that it was the ontogenetic approach which helped Freud to realize that, what had been initiated as an attempt to investigate etiological factors in hysteria, had led to nuclear parts of a new psychopathology and psychology (Freud, 24, Kris, 44, 45). It would be a fascinating essay in the history of psychoanalysis and a worth-while contribution to the history of science in general to investigate in some detail how Freud's views developed and how, based on data from the analysis of adult patients, insight into the psychosexual development of the child was gradually gained. We know in general terms that the reconstructive method had enabled him to recognize regular maturational sequences in the child's life; this unparalleled and uniquely successful procedure cannot merely be evaluated as an awe-inspiring feat of that one observer; it has at the same time established the fruitfulness of psychoanalytic observation as the method of ontogenetic inquiry. However, the individual steps by which Freud reached his conclusions have never been demonstrated. No such detailed investigation will here be attempted. I shall have to limit myself to tracing a number of trends in contemporary research to their initial stages. In order to serve this purpose I am introducing a somewhat arbitrary division in the history of psychoanalytic

¹ Contribution to the Panel on "Psychoanalysis and Developmental Psychology," held at the Meeting of the American Psychoanalytic Association in Detroit on April 29, 1950

² From the Child Study Center, Yale University, School of Medicine

child psychology I assume the existence of a chronological dividing line constituted by the early twenties, when several important developments in psychoanalytic thinking occurred. Though they were closely interrelated it seems permissible to start with an enumeration. The formulations on psychic structure which replaced the assumptions on the topographical stratification of the psychic apparatus—i.e., the formulation of a psychoanalytic ego psychology—opened new vistas in the area of developmental psychology. The emphasis on aggressive impulses directed attention to hitherto less closely observed manifestations of behavior. Simultaneously clinical data directed general attention to the part played by preoedipal experiences in the development of neuroses.

These theoretical and clinical developments, each in turn and all of them in their interdependence, were bound to influence the development of therapeutic technique, to enlarge the scope of psychoanalytic therapy and, consequently, to encourage attempts to vary procedures in adjusting them to cases hitherto out of reach of analytic understanding. The most important, but not the only instance of this tendency was the development of child analysis.³ Its independent contribution to psychoanalytic thinking in general and to the psychoanalytic knowledge of childhood in particular, strengthens the idea of the chronological dividing line—a device that in the course of this paper will not be justified any further. We will rather operate with the idea of two phases in the history of psychoanalytic child psychology: moreover, for the sake of clarification, in pointing to differences we will always imply and occasionally refer to before and after as means of characterization. The differences to be discussed will be related to three interdependent and overlapping areas of problems. We shall discuss first the consideration of the environment (or the development of psychoanalysis as learning theory) second a specific aspect of this general area, the problem of object relation and third, child observation and trends in current research.

I THE CONSIDERATION OF THE ENVIRONMENT

During the various phases of Freud's development, emphasis on the importance and interest in the effects of environmental conditions was subject to change though fluctuations in emphasis were never extreme. At certain times of Freud's development the quest for an understanding of the mental apparatus and its propensity to react even under minimal

³ See Anna Freud (16). One should not in this connection overlook the techniques developed in dealing with delinquents first by Aichhorn (1) and later by Staub (62). Experience with delinquents may well have been a formative element in the development of Alexander's (2) views on technique with their overemphasis on corrective experience.

external stimulation stood in the foreground, at others the external sources of stimulation were studied in great detail.

Shortly after Freud had become aware of the extreme importance of childhood experiences for the etiology of neuroses, he formulated a set of hypotheses which one might call 'environmentalist' to the extreme. The seduction hypotheses of 1895/96 not only stated that hysteria in the adult was due to seduction of that adult during his childhood but went considerably further, it envisaged the interaction of familial influences. The best-elaborated part of these assumptions stated that perversion in the seducer produced hysteria in the seduced. This assumption, which postulated a high incidence of adult (parental) perversion, enabled Freud to recognize first the improbability and shortly thereafter the incorrectness of his assumption (24, pp 229 ff). He himself described the crisis in his life and the development that followed—the emergence of new insight which evolved from the initial failure. Since the reports of his patients did not describe real events but fantasies, the study of fantasy life became essential. The study of these phenomena led to the discovery of the oedipus complex and to that of the various manifestations of infantile sexuality, and hence to the development of a set of nuclear hypotheses of psychoanalytic child psychology.

If we try to comprehend these early vicissitudes in theory formation in more general terms, we may say that a shift had occurred. The seduction hypothesis maximized attention on concrete experiences to which the child was exposed; the later orientation was implicitly based on the supposition that relatively minimal external stimulation would produce the reactions observed; and these reactions, the working of the mental apparatus rather than the concrete environmental conditions, were investigated in detail.

It would be misleading to take this description of a shift in Freud's interest at the turn of the century and during the subsequent decade too literally. It was not equally true of all parts of psychoanalytic work at the time and the division of interest was at no time sharp; yet it existed.

Let us turn to an illustration. In the case history of Little Hans the child's mother and father are extensively characterized, but it is not their personalities or the interaction between their own and the child's proclivities which are mainly studied. They are primarily, though not consistently or exclusively, seen as agents from whom the stimuli to which the child reacts are coming or have come. The main considerations center on the sequence of these reactions and their economic and dynamic interrelations with other experiences of the child. Only when the problem of his identification with the parental figures is envisaged father

and mother are treated more as individuals than as agents (Freud, 20)⁴

Without a discussion of examples to the contrary which are not infrequent and clearly prepare the future, we may generalize and state that during the whole of what we here designate as the first period of psychoanalytic child psychology the distribution of interest was approximately of the following kind: it remained focused on typical reactions of the child, on their sequence, and their genetic, economic and dynamic interrelations. Environmental conditions, though recorded in detail, were mainly considered as the source of such required experiences: there was something unavoidable about them.

The change in outlook occurred largely in relation to the development of ego psychology. The way in which this change was effected can best be illustrated if we turn to one of the most crucial applications of ego psychology, to the problem of anxiety. The older toxicological theory, which had assumed that undischarged libidinous tension was transformed into anxiety, was abandoned in favor of one which considered the danger situation as its center. Anxiety as a signal mobilizes defense against danger, anxiety as a symptom may then in turn be experienced as danger against which defenses are being mobilized. The theoretical setup is no longer a physiological one but rather a biological one, organism and environment are seen in their interaction. At the same time, historical factors gain an even greater relevance: the ontogenesis of the reaction to danger, the history of danger experiences and the history of defenses against them are recognized as decisive. The gain for the elaboration of psychoanalytic views on child development was very great indeed.

The development of the child was no longer viewed only in terms of crucial conflicts and typical danger situations related to the maturational sequence in libidinal development. First the contribution of aggressive proclivities to each of these phases and conflicts was considered and initial attempts were made—which are being continued (Hartmann, Kris and Loewenstein 35)—to view the interaction of libidinal and aggressive drives in each of the typical danger situations of childhood. Soon, however, the study of typical danger situations gained in scope. It became possible to take the stages of ego and superego development into account. In a number of instances at least one succeeded to correlate the use of certain mechanisms of defense to certain situations and developmental phases and thus, however incompletely and tentatively, to establish certain facts in the regular development of the mechanisms of defense (A. Freud, 14).

4 The distribution of interest is somewhat different in the case of Dora. And yet in spite of the unparalleled vividness with which the actors of the drama are presented even in this case history attention is not fully focused on their individual traits.

But at the same time it seems to me that the experience gained in the decade of which I spoke has in one decisive area facilitated a decision in the controversy between the two schools of child analysis. That area concerns what previously in this section I called "the consideration for the environment." Anna Freud's approach derived its peculiar vividness from detailed scrutiny of the child's concrete situation, in Melanie Klein's reports these elements play no comparable role. The psychic events which she describes as having taken place during the early months of the infant's life are cataclysmatic. They seem, therefore, hardly touched by the ways in which stimuli from the outside reached the child through the mother's ministrations. The drama between breast and mouth, visceral tract and muscular apparatus is enacted with little regard for external trappings.

It is here where the experience of a decade has facilitated the decision. From very many and independent sources we derive data that contradict the meaningfulness and fruitfulness of such an approach. Psychoanalytic child psychology has undoubtedly made a shift towards the environmentalist position. I shall not attempt to give in detail the evidence which brought this shift about. It was inherent in the developments initiating the second phase of psychoanalytic child psychology. Psychoanalytic ego psychology had, as we said, re-emphasized the character of psychoanalysis as a psychology of adaptation, of learning⁶ and clinical data have implemented these general assumptions as far as the child's earliest experiences are concerned. In speaking, as we did before, of the importance of preoedipal conflicts we really referred to the uniqueness of the mother in human life. While one might say that the discovery of the oedipal conflict was centered on the male child, the gradual but rapidly growing insight into the general importance of the preoedipal phase was initiated by renewed interest in the development of female sexuality (*Mack Brunswick, 6*)⁷ and only more than a decade after the preoedipal development of girls had been discussed a similar attempt, based on case material, was undertaken for the boy (*Lampl de Groot, 47*).

Next to this purely psychoanalytic material stands a vast array of data derived from analyses of mothers' various therapeutic techniques practiced with children in child guidance setups of different kinds and last but not least, clinical impressions of child analysts and analytically

6. See Hartmann(30). Both terms, adaptation and learning require closer definitions. This has recently been emphasized for the term adaptation particularly by P. Weiss(65) and by H. W. Smith(55). As far as learning is concerned a point of view that stresses complexity and warns against simplification has recently been presented by F. Beach(3).

7. For a historical survey see R. Fliess' introduction to the respective section of his *Psychoanalytic Reader*(15).

oriented child psychiatrists that stress not only the general intimacy existing between mother and child but a particularly close relationship between the behavior of both. No better and more dramatic illustration of this insight could be quoted but the universally accepted idea of treating a small child by treating its mother, as if we were in fact still faced with one organism—an idea which many years ago, in a meeting of the Psychoanalytic Society in Vienna, G. Bibring-Lehner expressed in speaking of mother and child as a unified system.⁸ At the same time the various procedures of simultaneous treatment of mother and child have produced a great deal of material that illustrates the types of interactions existing between both. We are entering here into a vast area of recent research. Its clearest manifestations may well be seen in some of the extreme hypotheses advanced. There are those who try to establish a definite relation between one type of maternal behavior and a symptom or group of symptoms in the child: children with a predominance of psychosomatic symptoms are children of certain kinds of mothers (M. Spierling); there is a mother of the child with eczema (R. Spitz, K. Wolf) and there is a mother whose children become stutterers (P. Glauber). Before we turn to a more detailed examination of this trend in recent research it seems appropriate to enlarge the theoretical foundations from which this account had started.

II THE PROBLEM OF EARLY OBJECT RELATIONS

When late in 1943 Margaret Ribble's book *The Rights of Infants* was published and the quest for 'early psychological needs and their satisfaction,' indicated in the subtitle, was answered under the sloganized heading 'food is not enough,' a trend of psychoanalytic thinking and investigations that had gradually developed over many years suddenly reached the general public. Before we turn our attention to these antecedents it seems appropriate to state how much we owe to Margaret Ribble's own investigation, to those of Margaret Fries and to the long set of investigations on the consequences of early institutionalization of the child, to which R. Spitz has contributed so decisively (56, 57). These studies helped us fully to realize that in extreme cases the lack of adequate object relationship in infancy may threaten the infant's life, may cause serious and even irreversible changes in areas of maturation and create psychosomatic disturbances the extent and impact of which is not as yet fully known.

In these and similar inquiries the field of investigation was not limited to the child, it included and frequently was centered around the

⁸ See for similar formulations also E. P. Hoffmann (57).

mother and the family setting. It is in this connection that the problem arose of how to investigate the mother's personality, which standards to apply and what observations to recommend in order to establish a link between her behavior and the symptomatology of the child. The psychoanalyst or child psychiatrist who had to deal with similar problems in consultation was, it seems to me, never seriously in doubt as to how to proceed. The approach of the psychoanalytic clinician has guided a group of workers at the James Jackson Putnam Children Center in Boston in formulating general assumptions in this area. B. Rank, M. C. Putnam and their collaborators assume quite generally that the child's personality bears the imprint of the mother's personality. This general problem was and is being studied in a specific area, in cases, in which the emotional detachment of the mother (in some cases the detachment of the psychotic mother) is viewed as an etiological factor in the condition of the child of his psychotic, atypical or arrested development. Several cases which were published give evidence of the application of these assumptions to therapeutic procedures. With the re-establishment of the emotional climate in which maternal behavior is assumed not to have met the child's needs not only considerable therapeutic progress could be demonstrated but the type of processes in themselves which were observed during treatment, carried confirmatory value (B. Rank, 49-51; B. Rank, M. C. Putnam and C. Rochlin 52).

In my opinion the decisive assumption in this area seems to be connected with the criteria used in assessing the mother's attitude. I am not sure whether in what follows the opinions of the workers at the Putnam Center, in particular the views of Mrs. Rank are correctly rendered or whether I have interpreted their views for my own purposes. I read them to state that the overt behavior of a mother to her child can only be evaluated with difficulty—i.e. can not simply be measured or rated—unless it is seen as expression of and in relation to an unconscious fantasy. It therefore does not make much sense to speak in general terms of maternal qualities rather is it essential to study in detail a mother's attitude to a specific child. The assumption that behavior is an expression of an unconscious fantasy—an assumption which the psychoanalytic clinician is bound to stress—permits us partly to account for the confusing differences in mother-child relations within one family.

Hypotheses of this kind seem to me to represent a significant advance since they effectively implement older theoretical assumptions to the extent that some of these assumptions seem to become fully meaningful only now. When in 1926 Freud(22) entered into the discussion of typical danger situations to which the human child is exposed he distinguished two—the two most archaic ones—which have a direct bearing

on object relations the danger of losing the love object and the danger of losing the object's love.⁹ The first represents the anaclitic needs, the second the more integrated relationship to a permanent, personalized love object that can no longer easily be replaced.

It might well be that this basic distinction will have to be refined, that differentiations will have to be introduced and that, for instance, the question of the capacity to accept substitute objects will have to be correlated closely to the various phases of the child's ego development. Quite obviously, what is true of any other division into phases in the child's life is also true of this distinction: there are not only fluctuations from one type of object relation to the other, older one, but the two types normally overlap. The fear of object loss never quite disappears: the fear of loss of love has added a new dimension to a child's life and with it a new vulnerability. Quite possibly, then, in studying child development further and in greater detail, we might find it convenient not only to introduce "sub-phases" but also to describe the simultaneous distribution of both types of object relation in one child, e.g., in terms of a ratio. But this does not detract from the value of the distinction established by Freud, on the contrary it enhances its importance. His distinction between two types of attitudes to the object gains in significance by its relation to the child's ego development and describes a decisive step in this development (Hartmann, Kris and Loewenstein, 34). One might use as an illustration what at the same time was an unintended (and as yet unrecognized) experiment at validating Freud's distinction: i.e., an experience made at the Hampstead Nurseries in London. When their toddler population did not react in any way to educational pressures by the nurses dealing with them, the suggestion was made to substitute for the various nurses dealing with the whole group each time one nurse permanently or predominantly dealing with a smaller group. Anna Freud and Dorothy Burlingham (18) describe the effectiveness of this device. We may say in Freud's terms that the anaclitic and transient object relation had been outdated, and a more permanent attachment was needed in order to facilitate the control of impulses by identification. For the sake of pleasing *their own* nurse or of winning and retaining her love the toddlers became clean and quieted down. I have little doubt that a similar explanation applies to other types of behavior noticeable around

9 A fairly large literature on the fringe of psychoanalysis consistently ignores Freud's views in this area or manipulates his statements to mention only the most glaring examples. Suttie (63) in England and E. Fromm (26) in this country. The rapidly growing number of contributions on "separation anxiety" rarely stress that they are simply variations of the theories of Freud against whom they prefer to polemicize. For psychoanalytic elaborations on the problem of separation anxiety see recently Odier (48).

the one year limit—particularly in the details of the mother-child relationship. The increasing demands for the mother's presence, the clinging which extends to the bedtime rituals may well be connected with the new type of need arising at that time—the need for the object's love.¹⁰

It seems that the further study of object relations and their bearing on ego development may also prove its value for an understanding of the clinical problems of psychotic, arrested or atypical development to which we referred before. In some of these cases we find indications of a comparatively undisturbed development during the earlier phases of infancy, up to a point, during the second or third year of life, when the picture suddenly changed or a change became manifest. In a case in which, to some extent, a similar process was jointly observed by the Rooming-in Service (Dr. Edith B. Jackson) and the Child Study Center (Dr. Milton J. Senn and staff) at Yale, a closer study of the data strongly suggested that the type of environment and care—overindulgent in a fanatical sense—was 'appropriate' during the first year of life, but the very detachment which is the corollary of a fanatical attitude did not constitute an object relation that could meet the requirements of subsequent stages of the child's ego development.

Observations of this kind, tentative as they are, may become strategic in more than one sense, since they draw our attention to gaps in our knowledge which seem of considerable relevance. By what criteria, by what observational techniques or by what testing procedures will we be enabled to recognize such and similar symptomatology before it becomes manifest: what are the methods to spot danger before it appears?

Without entering into an answer to these questions at this point, it seems that the stress on certain sectors of ego development rather than on others—on the social and learning sectors in the widest sense of the word—has proved to be useful (Spitz, 59). A challenging formulation of a similar view I find in a statement by K. Wolf according to which relationship to human objects has to be firmly established "to enable infants to form relations with inanimate objects."¹¹ This statement formulates more concretely a general impression shared by many, viz. that during

10 Its at least initially insatiable character may indicate that novel needs may express themselves by older pathways—by archaic cravings. Even under normal circumstances this frequently sadistic and therefore often not fully satisfactory child-mother relation is many a time soon to be overshadowed by the concomitants of the training process. In such cases the anal expression of aggression is substituted for the oral one—a sequence familiar from reconstructions in analyses of adult patients.

11 See Spitz-Wolf (61, p. 103). In the text it is said that "libidinal" object relations have to be firmly established. I take this to be a shortcut for both libidinal and aggressive cathexes.

the earliest phases of childhood the development of many ego functions tends to be directly dependent on the nature of the object relation—an impression that fully satisfies and in turn justifies some of our metapsychological assumptions. To put them in briefest form the assumption that the energy cathexis of the ego as an organization is derived from object cathexis, is a necessary part of Freud's formulation concerning the nature of psychic structure, one further step, outlined by him and elaborated by Hartmann, assumes that the cathexis of the ego with neutralized energy (desexualized libido and desaggressivized aggression) is a guarantee of the autonomy of its functions (Hartmann Kris and Loewenstein, 35, Hartmann, 31). It seems only sensible to insert into this chain of propositions some which take the nature of the object relation into account. Thus we might assume that the more satisfactory the object relation is the higher we are to estimate the chance of a successful neutralization of that energy which by identification becomes available to the ego. If we want to propositionalize further and thereby to contribute to a closer circumscription of what might be meant by 'satisfactory object relation' in the context of these assumptions, we are, it seems, driven into one direction. The 'better,' i.e., the more completely, aggressive and libidinal energies are fused in the cathexis of the object, the higher the chances of a successful neutralization. At this point a possibility for verification seems to open up: we know from clinical experience of what significance the freedom to manifest aggression can be in childhood, might it not be that early manifestations of this kind in sucking or biting, in twisting or grasping the mother's body could supply indices of a freedom to attack an object or part object that is so securely invested with libido that no harm can reach it by its investment with aggression?

These attempts to establish interconnections between various Freudian hypotheses in the area of ego psychology with our developmental interests have led us far afield. Once more the question presents itself how similar problems had been dealt with in what we here called the first phase of psychoanalytic child psychology. At first there were, quite obviously, some or even a good many problems that had not been considered at all. Some others, such as the questions connected with the sphere free from conflict or autonomous ego functions, to which Hartmann(30) has directed attention appeared out of context. Some of the data, pertaining to the problems raised by Hartmann, formed in some instances part of the qualitative descriptions given in case histories, they were part of an area that contributed to improve general understanding of the patient, but as far as psychoanalytic propositions were concerned

that area was at the time 'no man's land.'¹² Other problems were naturally familiar but the context in which they appeared was different. Danger situations to which the child was exposed and his traumatic experiences were not seen mainly in their relation to the behavior of love objects—they naturally were in extreme cases—but primarily in connection with the operation of "the means of education." We hear less of the fact that mother's absence or the lack of her devotion left its imprint, but we hear that weaning did. Next to the quantitative factors which are always stressed, very soon a second factor gained attention—the factor of phase specificity. Relevance or irrelevance of an experience was thought to be determined by the developmental phase in which it is experienced by the child. A little girl's reaction to the sight of the male genital will depend on whether or not she has reached the phallic phase. Some went further in saying that possibly the frequent exposure to similar experiences would accelerate the process of reaching the phallic phase.

When similar problems are being discussed during the "second phase"—the change seems to have occurred gradually during the thirties—a larger number of factors is taken into account. The situation in a specific crucial period can no longer be described only in terms of psychosexual development; equal consideration has to be given to that of the aggressive impulses, to the development of the ego and to that of object relations—in addition, naturally, to historical factors, i.e., previous experiences that determine present behavior (Hartmann, 32). Thus the reaction of children to air raids (A. Freud and D. Burlingham, 17) has been explained by taking a multitude of factors into account. The calmness or excitement of the mother with whom the child identifies himself, the question whether the child had lost a member of his family in a previous raid, the closeness of destructive id impulses to the ego, and finally the closeness or distance from the castration complex. Only in taking account of such a multitude of factors did it seem possible to account for the fact that children of certain age groups seemed frequently less afraid of air raids than adults expected them to be.

In a similar sense, the problem concerning the means of education has become more complex during the second phase of analytic child psychology than during the first. Few if any clear-cut rules can be estab-

12. There can be little doubt that one of the strongest incentives for Freud's reformulations was the desire to cultivate or conquer "no man's land": his starting point was frequently the notion that a certain type of behavior proved to have unsuspected clinical relevance—and the attempts to elucidate this relevance determined in part the selection of the next step in the formulation of his new propositions. The expansion of psychoanalytic propositions during the last decade—for instance in Hartmann's contributions followed, as far as I can see, similar principles.

lished rather, every discussion of the handling of the means of education must take into account a multitude of developmental factors. As far as the alternatives between indulgence and deprivation (discipline) are concerned, a formulation can at least be attempted.

Indulgence aims at the reduction of tension by satisfying the id impulses; it also helps to establish the child's dependence on and identification with the educating adult. In establishing and reinforcing the norms of desired behavior, deprivation (discipline) supports the ego in its attempt to gain control of id impulses. Were it possible to represent each of the typical conflicts between id and ego by means of a curve, points or stretches might be suggested on which increased indulgence or increased discipline might help to improve the chances of successful conflict solution. This can clearly only be considered as a model intended to clarify our thinking. It implies a number of assumptions, not all of which can here be made explicit. By successful conflict solution is implied the existence of an optimum of tension or an optimum of intensity of conflict in which the child achieves gratification and mastery of its impulses. The only measure at present is whether the child's development is favorably or unfavorably affected by the conflict which he has learned to resolve (Kris 44).

Thus every step we take and every formulation we achieve implies one connection—that between our set of data and a clear and detailed notion of what constitutes normal child development. Is this not the very area, one might ask, which a host of investigators in academic child psychology has pursued, are there not data assembled which could satisfy all needs? However rich these data, their bearing is limited; they are more useful where mere maturation is concerned, or the development of motility and intelligence is at stake, in other words they are more useful for certain ego functions than for others. The capacity of the ego to cope with conflict and anxiety, the chances of achieving positive synthesis of tensions—briefly, the development of all those functions of the ego that have a direct bearing on the structure of personality is known only in unreliable outline. There seems to be wide agreement that the psychoanalytical study of child development would fill an urgent need, and promises the only way to answer the questions with which we all are occupied, questions in which the problem of prevention is omnipresent. Let me here list some of them. How soon can we, from observational data, predict that pathology exists in a given child? how soon can we spot it from the child's behavior, from that of the family unit, or from the history of mother and child? Which therapeutic steps are appropriate to each age level and its disturbance, or to each typical group of disturbances? The problem of diagnosis and indication requires constant

refinement, the severity of one isolated symptom does not lend itself as indication for therapy (ubiquity of infantile neurosis) The self healing qualities of further development are little known How much can latency, prepuberty, or adolescence do to mitigate earlier deviation or to make the predisposition to such disturbances manifest?

III CHILD OBSERVATION AND TRENDS IN CURRENT RESEARCH

Psychoanalytic views on child psychology are based on two sets of data, on data gained by the method of reconstruction in psychoanalysis and on those gained by direct observation of children The relationship of these two sets of data to each other is of considerable importance for any discussion of problems of research First we have to stress that the relationship has not remained stable throughout the development of psychoanalytic child psychology During its first phase observational data largely provided confirmation or supplementation of insight gained by reconstruction During the first two decades of the century, the psychoanalytical periodicals carried frequent collections of accidental observations which fulfilled these requirements During the second phase, observational data were collected more systematically and used for other purposes They were expected to provide decisions where alternative hypotheses had been advanced by reconstructive methods (Waelder, 65) and to contribute to an understanding of areas of behavior, to which reconstructive hypotheses had not been able to gain access e.g., to the details of the infant development during the preverbal stage However, the main difference between the first and the second phase of psychoanalytic child psychology lies elsewhere During the first phase, the data based on child observation seemed to form an isolated and marginal field of interest, more closely related to psychoanalytic education or pedagogics than to any other part of psychoanalytic thinking (Hoffer, 36) During the second phase, the tendency developed to integrate observational data into the general flow of psychoanalytic thought and to relate them also to the therapeutic technique of psychoanalysis

The value of observational data has never been in question in Freud's mind He deplored that, while writing the *Three Contributions*, he had not been able fully to utilize observational data though even at that time they supplied some isolated hints and some valuable pieces of information (Freud, 19, p. 71 footnote added 1920)¹³ Freud's interest in this problem area extended over many years it led him to develop many aspects of psychoanalytic interpretations in considerable detail and was

¹³ In view of such explicitness it is hardly understandable how it could have been said recently that it never occurred to Freud to study the vicissitudes of childhood while they happened (Gorer 29)

subject to that same change in emphasis which the development of ego psychology brought about in many other areas. Freud's starting point was the traumatic experience to which we referred previously, i.e., the inability early in his work to distinguish between fantasies of his patients concerning their childhood and the recollections of events that had really taken place. There are ways to establish a decision but none—he argued later—is more decisive than the study of the disturbances of the child during childhood. While we might, at the present stage of our knowledge, doubt to what extent the neurotic disturbances of childhood—at least of later childhood—can be understood without reference to older experiences—i.e., to a past that would have to be reconstructed—there can be no doubt that, in speaking of childhood neuroses, Freud does not mainly refer to the psychoanalytic technique of study but to observational procedures (21, p. 300 ff). He develops his ideas even further and stresses the direct impact of the child's experiences on the etiology of neurotic illness: he does so, however, with some hesitation and in a polemic vein.

The importance of the infantile experiences should not, however, be entirely overlooked as so often happens in favor of ancestral experiences or of experiences in adult life, but on the contrary they should be particularly appreciated. They are all the more pregnant with consequences because they occur at a time of uncompleted development and for this very reason are likely to have traumatic effects. The work done by Roux and others on the mechanisms of development has shown that a needle pricked into an embryonic cell mass undergoing division results in serious disturbances of the development: the same injury to a larva or a full grown animal would be innocuous (21, p. 303).

The actual study of childhood experience seemed to Freud at the time particularly important in order to decide how much of the emphasis on some past event which is recalled or re-experienced in analysis is due to regressive cathexis and how much to the reaction to the original event. He kept the two conditions apart and never lost sight of the fact that this question was one which required investigation in each case. Others did not share in this view and this caution. Thus Ferenczi and Rank (12) not only stress—correctly—the fact that what appears in analysis as experience related to the past need not actually have been experienced before, but in writing their treatise they behave as if it could not have been experienced before reconstruction then has nothing to do with what had once occurred.¹⁴

¹⁴ The confusion of their point of view reveals itself in their wording. In the process of making conscious the libidinous tendencies operative in transference we are always faced with the reproduction of situations most of which had never been conscious. One might well say that their discussion no less than Rank's subsequent book on *The Trauma of Birth* represents a caricature like exaggeration of Freud's view on psychic reality.

When after a time lag of two decades Freud returned to a discussion of the problem of reconstruction of the past, his position had further developed. He not only discusses the criteria upon which such reconstructions have to be based but, in comparing the advantages of the reconstruction in archaeology to those in analytic work he points to the special difficulty of the latter: "psychical objects, he says, are incomparably more complicated than the excavator's material and we have 'insufficient knowledge of what we may expect to find'" (23, p. 362).

It seems permissible to argue that some of this knowledge can be supplied by child observation. In fact, there can be little doubt that the more detailed and concrete our knowledge of infancy and childhood is, the more knowledge we have to draw on, the higher will our chances be to present the patient with reconstructions that, in covering a large set of details, stimulate those displacements of cathexes which are part of the therapeutic process (Katan, 40) and may ultimately lead to the experience of recall.

There seems little doubt that contributions from child observation to reconstructions in psychoanalysis have become more frequent since concentrated efforts of many workers have contributed in various ways to the study of the child, the frequency of interpretations according to which, e.g., the child's reactions to the absence of the mother has initiated certain types of defenses, has probably increased considerably. So have undoubtedly many reconstructive interpretations in which the type of behavior one has reason to expect from a specific adult is taken into account. Briefly, it is, I believe, possible to show that the integration of all that we have learned of childhood and infancy into psychoanalytic thinking is taking place and that this integration is generally filling gaps in our knowledge and drawing our attention to less well appreciated types of conflict situations.

All this, however, characterizes only one aspect of the problem area. The other aspect concerns the contribution of data, derived from reconstruction, upon the observation of the child. We can briefly state our impression. However rich the data are that observational techniques supply, all that concerns their organization, the coherence of phenomena—i.e., all steps that we make in establishing hypotheses to be tested by what we observe—seem to me directly dependent upon what we have learned and are learning from reconstructions in psychoanalysis. This can only be stated as an impression since there are, no doubt, considerable differences between various observers and their equipment. What may remain meaningless to one, can very well gain meaning to another. However, as far as I can see, the history of recent research seems to confirm this impression. Let us turn to the area in which observational tech-

niques have contributed most during recent decades—the early features of the mother child relationship. The stimulus for intense observation in this area came from the analysis of women in whose early history the preoedipal mother attachment played a decisive part (see p. 30). But even the further hypothesis concerning the relationship of severe personality disturbances to lack of warmth in the earliest object relationship (see p. 31) has not been gained but only confirmed by observation. The hypothesis itself was first formulated in relation to analytic work with schizoid personalities in whose early childhood the attachment to parental figures was never able fully to develop (H. Deutsch, 9, 10).

It would be erroneous to generalize from such impressions that all that the observational study of infant and child will ever be able to provide is a test of psychoanalytic hypotheses, their confirmation, or their falsification in defined but limited areas. It is certainly true that this function exists, that as far as many questions are concerned, the analyst's knowledge gained from reconstructions does not offer a correct or sufficiently detailed picture of child development but at best an approximate one—a picture that needs to be implemented and supplemented, controlled and enlarged. But undoubtedly this is not the sole and dominant function of child observation, if its relation to psychoanalysis is fully utilized. Optimal conditions seem to require that the observational and reconstructive data be comparable. Such conditions would exist if observation was not limited to cross sections but organized in a longitudinal sense, if observation supplied data on life history (Sears 54, Hartmann-Kris, 33, Hoffer, 36). Such data would certainly not replace those supplied by psychoanalytic reconstruction but supplement them in at least two ways. Data obtained by psychoanalysis are naturally selective. They not only contain more precise information on areas of conflict involvement than on areas free of conflict (see p. 35), but even within conflict involvement their selectivity has to be taken into account. They indicate what had been important in an etiological sense and when it had become important. Events that seemed not crucial while they happened may later become crucial—earlier—neutral—experience when regressively re-invested may become traumatic. The simple comparison between two sets of data—selective and weighted ones and the unselected ones, collected without reference to the dynamics that may suddenly change their importance to the individual—such a simple comparison might prove to be immensely instructive. Such comparative study of data would be particularly interesting (according to suggestions made independently by H. Hartmann and Anna Freud) if some of the subjects whose development would have been studied by observational techniques could then be studied under the condition of analysis. One might expect that investi-

gations of this kind would not only elucidate a large number of problems that have hitherto never been studied adequately—such as the problem of the development of memory—but there is a chance that the function of psychoanalytic theory as a potential point of integration of various approaches in the study of child development might here become of practical importance. Integration of knowledge in child development can at the present moment not be seen as detached from another problem to which we referred before—the problem of prevention. Only the systematic longitudinal study of life histories, combined with attempts to predict at each point all that can be predicted about future development seems to meet the requirements of the moment. This is not the place for detailed discussions of the question how general or how specialized such predictions should be, a question that has recently been discussed very lucidly by J. Benjamin⁽⁴⁾

It is probably best to assume that we will not only have to learn how to observe but also how and what to predict. That both observation and prediction can derive their rationale from the coherent dynamic picture which psychoanalytic theory has to offer seems to me obvious. The two approaches—the one by reconstruction, the other by observation—are bound to overlap but cannot be made to substitute for each other. No observation and no longitudinal study has replaced or, I believe, will replace the value of the psychoanalytic observation proper for the study of child development. It is not only the method which provides relevant data otherwise not obtainable, it is not only, at least frequently, the one way to establish the etiological relevance of experience in the child's life but it also is the method to show how various phases of the past were interrelated—to see the life history as a whole, as it is organized by the personality and in turn has organized the personality. But this factor in itself establishes its limitations. It is that factor with which Freud was engaged in a life-long struggle. The telescopic character of human memory—to use an expression of Phyllis Greenacre—suggests the necessity of the study of the very elements which constituted the unified picture. One may at this point raise the question which kind of observational setup is most suited to serve our purpose. Is it the study of the normal or that of the sick child, the study within the family or that within an institution? Every setup, every observational technique can provide us only with a partial answer, can only make part of the problems accessible.

There are those who want the burden to be shifted to most exact, most continuous observations of the family setup. To state an extreme: The shadowy observers who live with the family would obviously, in the opinion of some writers, disrupt the family and even the most shielded home visit has its temporal or situational limitations (Dollard, 11). The

advantages of the residential nurseries to which we owe so much as compared to observation in nurseries and kindergarten are obvious. Yet the artificiality of the extra familial setup has its natural limitations. Limitations of observational methods are by no means accidental: they are partly inherent in the nature of the child. A large number of observers are inclined to draw conclusions from spot observations, i.e., from short time intensive observation in home or nursery. The limitations of this method, well known to these observers, can be illustrated by mentioning two problems—the problem of *behavior constancy* and the problem of the child's *regression rate*. The constancy of behavior under various situations is limited with the adult. It is not only more limited with the child, and infinitely so, but subject to extraordinary variations according to the child's state of development and a large number of individual factors: e.g., fear of the new, shyness, ease or difficulty in forming substitute object relationships, in fitting into the group, etc. The questions under which conditions and which children show a high or a low constancy of behavior and what constancy distribution is 'normal'—questions related to ego development—will be accessible only if a large amount of observations are combined and probably if various observational setups can supplement each other. The behavior to which I refer as regression rate may prove useful as an indicator in a similar sense. How far does a child regress under stress, fatigue, or in response to any one specific or many unspecified frustrations? With two year olds the end of a nursery period looks strikingly different from its beginning with some children more markedly so than with others. It is not only the expectation of the mother but, as some details indicate, the very duration of the nursery period that has instigated regressive behavior.

Advantages and disadvantages of each setup in which investigation is being carried out can be evaluated only if we take the working hypothesis of the investigators into account, in each such case the awareness of the limitations is part of both planning of research and evaluation of results. Let us here in conclusion, return to a point at which we interrupted our presentation. We referred to several hypotheses which related certain types of behavior in the mother to certain types of symptoms observed in the child (p. 32) some of these correlations seemed plausible, but all seemed questionable to the extent to which the problem of specificity of causation was involved. It seems that in each of the areas further research is required and in each the test of the advanced hypotheses could best be reached by a convergence of two sets of data, those gained in analysis and those which assembled over many years, may have been tested by predicting short term steps.

Moreover, once we have decided on such co-ordination of data we

shall sooner or later have to include the problem of hereditary factors in our investigation. Again if the double approach, psychoanalytic and observational, were systematically directed towards a study of identical twins, in both similarities and differences—differences that according to some preliminary impressions seem not unrelated to parental preferences—we would have advanced further toward what we take to be our goal. The integration of data and approaches in developmental psychology around a center rooted in the thought of Freud.

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CONFLICT AND AUTONOMOUS EGO DEVELOPMENT DURING THE PHALLIC PHASE¹

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In this paper I shall first present an observation made by a mother on her child, and then fragments of an analysis centering around the problem of learning to walk. They represent the two opposite approaches to the study of child development: direct observation on the one hand; reconstruction in the analysis of an adult on the other hand.

The observation was made by a patient of mine on her ten month old boy. It was first told to me shortly after the event and repeated a year later, with hardly any variations. The mother is a very intelligent woman in her thirties, endowed with an unusual sense of observation and psychological insight.

She described how her little boy, lying undressed in his crib, playing with his arms and legs, sat up,² kicking his feet back and forth, his heel touching his penis several times. The baby looked down to see what it was. His protruding abdomen prevented his seeing the penis. He started playing with his navel, pushing it in, then did the same with his stomach, and then suddenly saw his penis. With his right index finger he slowly touched his penis, barely coming in contact with it, then looked up at the mother with his face wreathed in smiles, repeating this two or three times, and each time with an expression of discovery.

Not convinced yet, he got up, crawled in the crib, again sat up, looking down, and when he did not see anything, looked back over his shoulder. Then only he pushed his stomach in with one hand and looked down with the other hand, touched his penis two or three times with an expression of delighted discovery. This maneuver was repeated by the baby several times, crawling away, then sitting down, looking back, pushing his stomach in, and touching his penis. The whole game lasted ten minutes. According to the mother, he would have con-

1 Contribution to the Panel on Psychoanalysis and Developmental Psychology, held at the Meeting of the American Psychoanalytic Association in Detroit on April 29, 1950.

2 She believes that it was the first time the baby sat completely naked in his crib for a prolonged period of time.

tinued but for her picking him up for his bath. In the bath tub, he kept looking down for his penis as if to be reassured.³

The child repeated the whole game two or three times after that—looking for his penis, finding it, touching it, checking up as it were, and then satisfied, he would start playing with something else.

This observation describes an important phase in the process of the formation of the body image. It is composed of two steps: one is the discovery of the penis, contact with which produces a pleasurable sensation, the second step consists in finding, experimentally, that this object, the penis, is not being left behind, lost, when crawling away, but stays with the body, belongs to it.

We assume that such an experience, in this or in another form, must be a typical phenomenon. From psychoanalytic observations on adults and children, one knows that at a later age, during the phallic phase of development, the boy experiences the impact of the castration complex. Under the influence of real or imaginary threats, or at the sight of female genitals, he starts fearing that he might lose his penis. Our contention is that this anxiety concerning the disappearance of the penis takes as its model the processes we have just described in the observation. During the formation of the body image, the infant goes through moments of uncertainty, which are resolved by the confirmation that the penis is an indissoluble part of his own body. We suppose that under the impact of castration anxiety this uncertainty might be reactivated in the form of doubts and fears that the penis could fall off or be lost.

It has been stressed that castration is preformed earlier, at the oral and anal stages. The loss of feces was considered as an anal castration, and the repeated loss of the breast or the bottle at the end of the feeding has been called oral castration. Among the reactions of an infant to the end of feeding, one might observe those of apparent complete gratification, where the infant falls asleep at the breast. We know that not every feeding is so complete. Frequently feedings are interrupted while the baby is still hungry. Sometimes also it seems that the infant is completely satiated, refusing any further food, but it falls asleep only with additional libidinal gratification, consisting for example, of sucking movements. Such instances of incomplete or interrupted gratification during feeding must constitute experiences in which the infant learns that the gratifying object can be lost, does not belong to its own body. Thus, in contrast to the reported observation of finding that the penis belongs to one's own body, the oral frustration might indeed be the earliest prototype from

³ The mother also told me that two weeks later he stood up in his crib and urinated through the bars, looking fascinated at the flow of urine. After he had finished he turned around looking back, as if to see where it was coming from. The mother thinks that on account of his protruding abdomen he could not see his penis.

which the process just described as well as the content of the later castration anxiety borrows certain of its elements

The second case was drawn from the analysis of a man in his early twenties, of which I shall present only those fragments which are relevant to our problem

When the patient was eighteen, he had a love affair with an older girl, which was broken off under decidedly painful conditions. For a short time after this traumatizing event, he presented potency disturbance. Its structure centered around the classical oedipus complex. There was, however, slightly more than the usual emphasis on the dangers emanating from a castrative woman. This latter trait could be linked to repeated, barely veiled, actual castration threats, expressed by his mother in childhood. The unfortunate events at the age of eighteen reactualized in the patient this dangerous aspect of the woman.

In the material brought out in the analysis, the image of the genital function centered around the well known equation penis = body. To be more precise, potency was linked by the patient in his fantasies with mastery of the body movements, as in swimming, jumping, running fast, whereas he linked his loss of erection with a very early screen memory which occurred to him in the latter period of his analysis. The real or fictitious event which the patient remembered was the following. He sees his nurse presenting him as a baby to the family assembled around the dining room table, to show that he can walk. He takes a few steps, and in front of his mother falls on the floor. He also seems to remember that he felt very much ashamed at the mother's laughter.

The patient had always remembered certain events of his early childhood particularly his childhood sexuality. In the analysis he widened the scope of these recollections to a degree which is more than usual. He even recalled the first name and certain traits of his wet nurse (which were confirmed by his family). She left when he was a little over a year old and he apparently never saw her again. In spite of all that, the recollection of his mishap while taking his first steps in front of his mother, presents certain characteristics of a screen memory. The nurse whom he sees is a nurse who came to his family when the patient was over two years old and certainly already able to walk. But the nurse of his memory played an important role in his life for another reason. The patient always remembered—and this was an unmistakably real recollection—that when he was over two-and-a-half years old this nurse masturbated him. The analysis even brought out memories of her permitting him to be present when she had sexual intimacies with her fiancé. Although this nurse stayed with him for only one year, his attachment for her had been very strong for her image haunted his sexual fantasies during his analysis.

The analysis of the screen memory confirmed what was partly remembered and partly reconstructed from other material—namely, that his attempts at seducing his mother were met with rebuff and castration threat. The showing off of his ability to walk in the screen memory, stands for the phallic exhibition of a later age which the nurse favored and which the mother rejected. The mother's rejection of his attempt at seducing her in childhood is represented in the screen

memory by her laughing at his inability to perform. This is directly connected with his later potency disturbance—the inability to perform after the girl with whom he was in love at the age of eighteen had hurt and humiliated him. What ever one might think of the possible reality of the scene in the screen memory, what is significant is that all through his childhood there were many activities, dreams, games, fantasies and daydreams which centered around the denial of the danger of castration by means of mastery of bodily movements.

In childhood, for weeks at a time, the patient would practice special, unusual forms of running. The fantasy accompanying this game concerned the wish to run so as to barely touch the floor. This fantasy was continued in dreams of being able to jump great distances and finally at a later period in typical flying dreams. In these, he was particularly gratified when his flying body would obey his slightest wish without any physical effort. Innumerable daydreams in prepuberty dealt with flying like a bird or inventing air planes.

The patient understood the meaning of these fantasies and dreams after the analysis of the loss of his first milk tooth. When he found another tooth hidden under the one just lost, he had the thought that he would never be toothless, there would always be other teeth growing. After this optimistic belief was interpreted to him as an assurance that he would never lose his penis, he suddenly himself understood a type of dreams he had been having from very early childhood. They consisted of flying out of the window in his crib, falling down with anxiety, and landing in the yard with a feeling of relief that nothing happened to him. It was only after the screen memory was analyzed that it was possible to understand why all these fantasy productions—the denial of the danger of castration, were expressed by either not touching the earth or floor, or by not being afraid of falling on the floor. However, all these dreams with happy endings did not prevent the patient from acquiring a mild form of phobia of heights at a later age. Nor are we surprised that his optimistic continuous denial of the danger of castration did not prevent his acquiring mild neurotic symptoms. Although the mother's castration threats put an end to his childhood sexuality, they did not harm him too seriously.

My patient attributed to proper functioning of bodily movements the symbolic value of proper genital functioning. One knows the sexual value universally attached to bodily co-ordination and mastery. We know what erotic value is attributed to grace in movement, and even in athletic performances and in the dance. You may remember that, long ago, Abraham traced the predisposition to railroad phobias to locomotor eroticism⁽²⁾. The analysis of the screen memory of my patient shows beyond a doubt that in it his own body symbolized his penis, and his ability to walk symbolized an erection, and the falling on the floor the fall of an erection. We assume that this symbolic equation is contemporary with or follows the phallic stage. It is only when the penis acquires its value that the boy's whole body is being unconsciously phallicized.

It is impossible to decide whether the event recollected in the screen memory had ever actually happened in this form. There is, however, no

doubt that the patient's childhood games, dreams, and daydreams were attempts at denial of the possibility of castration by avoiding a fall on the floor, or by minimizing its danger. The very fact that the screen memory chooses for the representation of the mother's rejection of the little boy's phallic exhibition his first steps and his fall means that learning to walk lends itself to such a symbolic equation. It is likely that the screen memory was formed during the phallic phase⁴ and reactivated during the patient's analysis.

Learning to walk is a maturational phenomenon, occurring long before the phallic phase. From the observation of children one must assume that it is highly gratifying. On the side of the instinctual drives, we might say that learning to walk must have considerable influence on canalization of aggressions into co-ordinated actions. It certainly is accompanied with libidinal gratifications. On the side of the ego phenomena, it may be said that it produces gratification of the pleasure of functioning (*funktionslust*) and of mastery of bodily movements. It obviously brings about a changed relationship to objects, the ability to reach them, and a change from passivity to activity, thus an increased mastery of the object and increased security against the danger of helplessness.⁵

Our contention is that all these phenomena, concerned with bodily mastery acquired through learning to walk, become the pattern for processes which will occur later on at the phallic phase.

The fragments of this analysis and the observation made by my patient on her little son have one thing in common. They show that processes of the phallic phase, such as the fear of losing one's penis under the pressure of castration anxiety, might indeed follow or reactivate traces of that period of formation of the body image, however short it may be, in which there remains an uncertainty as to the penis belonging to one's own body. Phenomena of the phallic phase—identification of the body with the penis, and of bodily movements with erections—are built on traces of instinctual processes and particularly on traces of ego changes acquired by learning to walk.

Among the most striking discoveries of psychoanalysis was the fact that certain ego functions develop in close connection with instinctual phenomena—the latter, served them, as it were, as models. It was indeed for these reasons that the ego was conceived as a part of the id, differentiated from it under the impact of the outside world. More recent studies of the ego, however, have shown the ego and the id as developing from a common, undifferentiated phase—the ego functions following an inde-

4 This assumption is based on some material of the patient's analysis which is not discussed in this paper.

5 The meaning of dreams of flying aside from its symbolic expression of erection might well express the child's desires for limitless freedom and mastery of body movements.

pendent development and soon acquiring their independent characteristics. For this reason the ego is conceived of as endowed with its own psychic energy.

The two observations just presented show that autonomous ego functions can serve as models to later processes in the instinctual sphere. Thus these cases become understandable thanks to recent assumptions on the nature of the ego, as formulated by Dr. Hartmann.

We see that interactions between ego and id are richer and of a more complex nature than one might have expected formerly. Not only do the instinctual drives leave their impact on the ego, they, in turn, might be patterned on ego functions.

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A CLINICAL CONTRIBUTION TO EARLY EGO DEVELOPMENT¹

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Not having at our disposal as yet any systematic study of infant development from birth, we are choosing an example from the case histories of our children with atypical development and hope to be able with these data to offer a contribution to the understanding of the formation of psychic structure, namely, how the ego (a substructure of personality defined by its functions," H. Hartmann) is molded under the impact of reality on the one hand, and of the instinctual drives on the other. With the same material, we shall highlight the vicissitudes of libido and aggression and their forms of expression. This approach, which stresses the significance of the early object relationship (emotional climate) for the understanding of child development, does not question the existence of preparatory autonomous stages of the ego although for reasons mentioned above it does not include a discussion of individual differences in infants at birth.

A few words to justify our procedure from the study of this group of atypical children: we have learned that their personality structure represents fragments of various stages of development showing high achievements of some of the executive functions of the ego while other manifestations of the ego or instinctual drives remain crippled or on a much lower level (18). These children show manifold individual differences but have in common a disturbance in their relationship to people, manifested in different forms of isolation or withdrawal. However, it has been our experience that with the gradual establishment of confidence in the person of the therapist, a breach in the isolation can be made which leads to a progressive building up of relationship to people and the outside world.

We can follow in such cases the unfolding of the capacity to recognize the existence of other people than themselves (i.e., object finding) and observe by what means the developing ego deals with the demands of instincts (sexual or aggressive) and reality. In our opinion, these steps rep-

1 Contribution to the Panel on "Psychoanalysis and Developmental Psychology" held at the Meeting of the American Psychoanalytic Association in Detroit on April 29, 1950.

2 From the James Jackson Putnam Children's Center, Boston, Mass. Marian G. Putnam, M.D. and Beata Rank, Co-Directors.

resent an approximation to the steps taken by the average infant in his development (as through a magnifying glass)³

In order to demonstrate how we enable the child with arrested development to emerge from a primitive infantile state into higher strata of development, we shall introduce the case of Olga R.⁴

Olga was referred to the Center at the age of three years, nine months, because of violent temper tantrums and non-conversational speech marked by echolalia and reversal of pronouns. She had virtually no relationship to people and was not toilet trained. From her developmental history we shall stress only a few pertinent points.

Olga was born by Caesarian section at eight and a half months because a previous pregnancy had been terminated by section at eight months due to hemorrhage from placenta previa. The first baby was stillborn. Because Olga weighed only four pounds she was kept in the hospital and away from her mother for twenty four days. The mother became *depressed* as she had after the loss of the first baby, and for two months after Olga came home she participated only slightly in her care by bathing her, etc., while the maternal grandmother took charge.

Olga cried night and day for three months with colic and diarrhea. "Formula went right through her." At four months she began to gain weight and to sleep and the colic and diarrhea disappeared. She has been a good though quite a peculiar eater ever since. Olga was consistently left alone in her crib and pen. She was an active baby, and the father reports that from the time she began to pull herself up—around eight months—she rocked her crib, standing up and shaking it vigorously, night as well as day, singing as she did so. She was weaned from bottle easily at ten months. Toilet training began at eighteen months but was resisted violently. She smeared herself with stool from head to foot from six months to two years and still occasionally at three. The mother who was disgusted with smearing used to hold the child under a sprayer, thus arousing her fear and resistance.⁵

Because of marital friction the parents separated when Olga was twenty months old. This occasioned the mother's second depression, she remained immobile on her back in bed, staring into space. During this time she gave Olga only minimal physical care. When the father rejoined them, when Olga was two years old the child reacted with violent temper tantrums. She began to talk at this time, but her speech was repetitious. There is a history of Olga being locked for hours in her room and disciplined harshly to correct her tantrums.

3 Following the example of Freud himself who drew his theories about normal development from the study of pathological processes.

4 Dr Dorothy Macnaughton carried the treatment of Olga R. and Miss Irene Andersen the work with the mother. We are using their notes to give the data of Olga's early history but are not discussing the course of the treatment which was carried simultaneously.

5 See the repercussion of it in manifold manifestations, especially play activity.

INITIAL DESCRIPTION

When first observed, Olga was a well built three year old, unhappy and extremely passive looking, with a waxy complexion. Her mouth was slack and generally open. The eyes, unfocused, looked through rather than at one. When picked up, Olga gave the curious illusion of lacking body substance and therapist felt, if not held tightly would have slipped through her arms. Her neuromuscular co-ordination, however, was excellent, and in body movement she was quick and light. At the same time, she showed unusual, bizarre posturing such as moving around in a squatting position without loss of balance or lying on the floor, her body arched backwards, heels almost touching her head. A most characteristic pose was a raising of her arms and hands, which were held aloft as if in a prelude to an act of active aggression.

CONTACTS WITH REALITY

Olga related herself to inanimate objects, readily naming and identifying them. One felt she used naming as a prop and guide to orient herself to reality. With people, however, she did not make conversation and when spoken to, merely repeated what was said to her. Sometimes she uttered quite complicated sentences, reminiscent of her mother's. Olga's voice, although musical and rhythmic, had a curious sameness about it, whether happy or sad. It had the same questioning, liting quality. She tended to rhyme, and even when making a statement, the ends of her sentences were left up in the air as though asking a question. She intermittently inverted her pronouns, referring to herself as "you". She was frequently unable to differentiate between men and women, and seemed curiously unaware of other children. Between her mother and herself there was little or no contact. She did not call her mother by name. Human beings seemed to exist for her only as "agents de frustration" from the outside world to shatter her precarious inner balance.

ACTIVITY

Her activities were bizarre. Observed early was a rhythmic rolling of the head and body from side to side, while she rhymed and sang. Although father reported Olga's wandering away, this was not noticed in our early contacts, in which she seemed content to stay in the therapy room. There was, however, a sudden and compulsive acquisitiveness. She would dart with the swiftness of a predatory bird, seize an object, hold it for a moment, and drop it, only to snatch another. Her aim seemed only to acquire, then abandon, and her pleasure only at the moment of snatching. Constant mouthing of objects was characteristic from the beginning, not merely a licking but a total activity of lips, cheeks and tongue, biting and chewing being conspicuously lacking. The chocolate bits re-

ceived from the therapist were her first experience of sweets. She applied the chocolates to her mouth with the flat of her hand in a circular fashion. The process seemed to be a combination of smearing and mouthing. Once in the mouth, Olga rolled them with her tongue in a playful way, reminiscent of a puppy playing with a candy.

This initial picture of Olga, sketchy though it is, may suffice to suggest that we are dealing with a personality showing scattered development (which we call the 'atypical' child) with the characteristic discrepancies between the libidinal and aggressive drives and ego development. Her libidinal development in gross contours shows overlapping or fusion of the oral and anal stages, aggression is still largely self bound or suspended in its expression, while in the main the ego development is scarcely beyond the undifferentiated phase.

According to our previous formulations, we have attributed such development to the lack of an emotional climate favorable to the development of an ego capable of mediating between the self and the outside world and conducive to the forming of early object relationship. When the ego recognizes only fragments of reality (part-objects), it develops single functions but without the central core built from the introjection of a stable maternal image, conceived as a whole, it does not acquire the synthetic function capable of controlling instinctual drives, both sexual and aggressive⁽¹⁰⁾. Its task to serve self preservation is frequently challenged or is maintained only as far as the body surface is concerned. The libido is invested exclusively in the self, all body zones are eroticized and the child pursues a state of excitability.

These children may be rockers, head bangers, regard their hands over time, clap their hands to their heads in a gesture of frustration, pull at ears or hair, and despite vigorous bodily activity seemingly have no other goal than bodily sensations, which in themselves shut out the impact of the environment. In their hand movements they both ward off the environment and draw inward. Although otherwise well developed, their legs fold when held for standing, an expression of their lack of readiness to move forward.

They also have a featherweight quality in contrast with the well integrated child whose body as well as personality has substance and resiliency. Along with the emptiness of the emotionally starved child is the impression of lack of body contours, an elusiveness when picked up—despite the fact that he may be well formed so far as body development is concerned.

Vocalizations are frequent and varied, but they seem to express the

same satisfaction as other bodily activities and to be a part of the whole picture of autistic mobility rather than communication.⁶

Does Olga's history justify the thesis of early deprivation? At a glance we are struck by *two periods of distress*. The first, in the first three months of her life, was characterized by the simultaneity of both physical and emotional deprivation (a) actual separation from mother for the first twenty four days because of the necessity of keeping the infant in an incubator and hot bed, (b) emotional separation for the following two months because of mother's depression, (c) physical distress for the first three months—colic and diarrhea. Olga cried day and night. We find Olga in the *second period of distress* at the age of eighteen months initiated by mother's depression over separation from father, lasting again for about two to three months, and followed by a violent struggle over the toilet training.

As constant, meaningful factors we have the relationship between Olga's parents. The father, an air pilot, an unstable and narcissistic person who constantly referred to his marriage as a 'trap' and a cage, had always demanded to be waited on by his wife, and with his comings and goings on flights, both actual and fantasied, kept the home atmosphere in a state of constant uncertainty. The wife, herself a narcissistic and infantile woman with a hostile, dependent tie to her own mother, was from the beginning so completely dependent on her husband that she could scarcely breathe without him. She had identified with his attitude that the child should be harshly disciplined whenever she interfered with their good times together. Mother's recurrent depressions are another factor. A severe one had occurred after the stillbirth of a baby prior to Olga's conception.

Hence all Olga's early life experience deprived her, at the most crucial and fragile stage of her emotional development, of the protective warmth of human contact (with her mother) which would make it possible for the infant to establish a confident anticipation of gratification of her needs and make possible the formation of early identification(1).⁷

6 Mrs. Grace Young, our psychologist who has considerable experience with infants subjected to institutions—those shunted from home to home in the early months—has made similar observations.

7 In our earlier quoted paper, *Adaptation of the Psychoanalytic Technique for the Treatment of Young Children with Atypical Development*, we roughly divided the mothers of our children into two groups. Those with diagnosed psychoses (a) mainly manic depressives who have had repeated hospitalizations and/or depressive episodes shortly after the birth of the child (b) schizophrenics with remissions. 2. Extremely immature individuals with narcissistic cathexes incapable of mature emotional relationships. And furthermore we said "To undo or release an arrest in the development of the emotional life of a child is to transform a static state into a dynamic process (mainly through the establishment of a relationship)(18).

THERAPEUTIC EVOLUTION

The therapeutic evolution was, therefore, geared to achieve the child's contact with reality by the following steps

A EGO DEVELOPMENT

1 *Stimulating the Child's Contact With the Outside World Through Gross Bodily Contact (Sensory Stimulation)*

In order to make contact with the child the therapist offered her person as a token of the outside world. Bodily closeness was combined with rhythmic movement and musical sound: the therapist sitting in a rocking chair with the child in her lap, singing nursery rhymes at first and later singing to her in a conversational way instead of speaking.

2 *Taking Over the Executant Functions Acting as a Partial Ego*

This was illustrated by Olga using the therapist's hand to open doors, untie knots and carry toys and her pocket to hold candies etc. The therapist, by becoming an extension of the child, enabled Olga to see herself in the person of the therapist as in a mirror. This partial identification prepared the way for

3 *Differentiation of the Child as a Being Separate from the Therapist (Outside World)*

(a) Through the Use of Games and Toys

This was gradually encouraged by the therapist through the introduction of little games: the first a gentle knocking of foreheads together like two little lambs drawing back and knocking again. A somewhat similar game of eyes was then played: the mutual approximation of the child's and the therapist's eyes together. This caused the child intense delight. Then followed peek-a-boo with the child held in the arms in which together they ran to look at their reflections in a mirror and then ran back again. These early games conducted in a very narrow area and on a small scale were later expanded by the child herself into the walking away and being followed game (let's go walking). Running away and being followed game (chase you" later me") then the Running away and calling game ("yoo hoo"). This game soon took the character of wandering from room to room where the child snatched up any object that came to hand. Whereas earlier such objects were dropped as soon as seized, now they were handed to the therapist to carry. It seemed as if this were the beginning of the child's ability to incorporate and retain objects using the therapist as an extension of self and as

the retention of objects became more purposeful her earlier squatting position disappeared. Instead, she might be seen sitting on the floor, legs extended in a wide "V," into which she collected many small objects, at first as if to take them into herself, but later for use in more sustained and specific play.

(b) *Through Exploring Reality in the Person of the Therapist*

By now she had begun to look directly at the therapist and finally to address her with the abbreviated version of her name. With this the personal pronoun was more frequently used, and she began to explore reality in the person of the therapist, her eyes, ears, nose, mouth, and fingers. The child's expression assumed a more vital quality, animation and beauty took the place of the former "dead pan" mask, and in her eyes was a hint of sparkle and humor.⁸

B. VICISSITUDES OF AGGRESSION

1. *Self-Attack as Reaction to Frustration Imposed by the Inanimate Environment*

When frustrated by any slight limitation, such as a closed door or a shut drawer, Olga howled, flung herself violently to the floor, her breath held, her eyes staring from a congested face, her whole body stiffened and arched backward, with heels almost touching her head. After an initial cry, she would launch into frenzied motor activity, arms and legs thrashing, body turning and twisting in mid air, as she rolled over and over in apparently purposeless discharge. In a prolonged tantrum of this sort, she might be observed scratching her own throat with both hands and banging her head against the floor. In an attempt to quiet her, the therapist would pick up the struggling, self-attacking child, and enfolding her in her arms, would talk or sing directly into her ear to soothe and restore the shattered outline of the self.

2. *"Freezing" (Isolation) Reaction Against an Attack by People*

In striking contrast to the self-attacking temper tantrum was Olga's reaction to an aggressive act by another child. She would allow a toy to be snatched from her without apparent response, and once, when jerked violently to and fro in a swinging boat by a boy, she passively allowed her body to be thrown around in the boat without registering any visible emotion except perhaps a mild relief when he stopped. She then stepped out of the still moving boat with remarkable agility and ran off as if nothing had happened.

The progress in therapy, which reflected the growing relationship to

⁸ Compare also the observation of blind children by Dr. Jane Allen Hallenbeck, Massachusetts General Hospital, Department of Child Psychiatry, Boston. "The children are helped to orient themselves and establish human contact through sensory stimulation from gross bodily contact, oral orientation, with a progression to rough but more goal direct handling, then to a more sensitive feeling."

the therapist and Olga's greater awareness of herself as separate from the outside world (recognition of reality) led to a

3. *Gradual Externalization of Aggression*

(a) *Teasing*

Appeared as a mitigated expression towards mother and therapist Olga would put her fingers in the therapist's mouth and ears, and even lick her cheeks. Although this was definitely exploratory at first, it gradually took on a playful, teasing, aggressive character. For instance, during examination of the therapist's ears, she would seize her earrings and throw them down. This teasing of the therapist was evident also in her animal identification play. She would advance toward the therapist on four legs and suddenly jump on her, pretending to scratch.

(b) *Flinging of Objects at Random (Diffuse Expression of Aggression)*

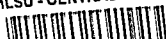
This was not yet goal-directed in that she did not aim for anybody or anything specifically. This random throwing alternated with temper tantrum like outbursts for a long time (self bound aggression)(19)

(c) *Goal directed Attacks*

(1) **ATTACKING THE ENVIRONMENT INSTEAD OF HERSELF** One day a boy snatched a paper necklace away from her. She went into a violent temper tantrum, attacked herself and said "You want to be a worm. You want to be a worm." When the therapist said "You do not need to be a worm. You do not need to hurt yourself." Olga stopped abruptly, picked up a block, and flung it at the wall with "I want to throw in Mummy's face." With the appearance of this throwing in order to attack the environment rather than herself, came a striking change in reaction to attacks or frustrations imposed on her by other children. Instead of passively accepting what they did with no show of aggression as she had done at first, she began to react with temper tantrums. With this came a new awareness of children. She stopped calling them 'angels' and began calling them 'kids,' even trying to give them names.

(2) **ATTACKING MOTHER.** Mother reported at the same time that Olga was not only teasing her in the same way as she had teased the therapist but actually had flung a shoe at her when she was reading. From then on began an active attack on mother by flinging objects at her and kicking her. It was noticed that Olga was not yet able to use her hands directly in bodily attack on her mother, but only indirectly by throwing things at her.

(3) **ATTACKING THE THERAPIST** The first goal-directed attack on the therapist herself came later. It came as a displacement in retaliation for an other child's aggressive attack on herself, shortly after which she attacked the therapist directly, hitting and kicking her. Following this sudden attack, she showed a need to control such impulses and there followed a series of games in which she was kicking herself up. The most outstanding of these



C LIBIDINAL DEVELOPMENT

1 The significance of the oral tactile and oral incorporative components of the libido were manifested first in their inhibitory expression in Olga's disinclination to chew and her finicky eating habits although she showed greed in self selected items such as bread spaghetti fish and jello the latter she squeezed and smeared through her fingers. The concomitant inhibition⁽⁶⁾ of mouth eyes and hands was strikingly shown in the contours of her slack salivating mouth her vacant widely dilated pupils and the curious position in which she sometimes held her arms and hands i.e. the elbows flexed forearms raised and the fingers stiffly extended and fanned out as if to prevent aggressive action (or position of defensive surrender Kamerade)⁹ (4)

As treatment progressed oral exploratory pleasure seeking expression was observed in her licking mouthing and fingering of inanimate objects and licking and fingering of the therapist's face. Almost immediately followed the oral aggressive element and Olga used her mouth more for chewing objects and her hands for snatching them. As licking and mouthing turned into biting we had a parallel in the hand activity which changed from stroking to snatching and then to scratching first of inanimate objects then people as well as herself. Later there was observed a more retentive quality about both her hands and mouth (incorporative activities)

2 The early gastrointestinal disturbance of the first three months (colic and diarrhea) gave weight to the anal component of Olga's libidinal drive. The smearing of feces over herself and crib started at the age of six months and persisted until the age of two years thereafter continued intermittently as a weapon against her mother making the toilet training a battleground between them. In her activities we see a number of anal derivatives her preoccupation with geyas (bowel gas) and refusal to touch clay. As her first activity in relation to clay she ordered the therapist to make worms. From here on her inhibition receded she began to make the worms herself became more and more obsessed with them identifying them with her bowel movement (a great big worm over the a a s). In her personality traits we see other anal derivatives as for example compulsive acquisitiveness stubbornness and ambivalence.

D PLAY ACTIVITY

Olga's play activities showed most vividly the progress of the child's emotional development. The oral and anal libidinal trends were manifest throughout. At first she would amass small toys crouch over them name them to herself. Soon she appeared to derive pleasure from fingering and licking them and from stroking soft materials such as furs (oral tactile orientation). As treatment progressed however she began to enjoy playing more actively with toys which play was then elaborated to re-enact traumatic scenes in symbolic language. For instance the re-enactment of the primal scene in which Olga lay across the roof

9 Arrested movement may mean a protective attitude against hostile approach from outside" (F. Deutsch 4)

of a house, face down, licking and scratching it (role of active father) Many scenes in which she first drowned specific inanimate objects, then miniature dolls (being showered by mother) or put chocolate bits, marbles, then animals in cages or herself in a play crib 'Tiger's in the cage—he's much too big—oh, Tiger, Tiger, Tiger' (being locked in room by mother) Her play was then extended to include live objects as well, and was more frankly sadistic, i.e., seizing the tail of a cat, capturing beetles and turning them on their backs with their legs waving, pulling worms out of holes and torturing them until they died During all this highly sexualized, sadistic play activity, particularly with small, live objects, less so with toy materials, she pursued her victim with terrible intensity, her eyes glued to the object, her mouth working, her whole body tense and anticipant, and at the peak of the activity which culminated in the final act of destruction, Olga would stand back in her characteristic posture, upper arms raised to shoulder level, elbows flexed at right angles and forearms pronated, the fingers at first widely fanned, then clenching and unclenching, bent over her handiwork like a bird of prey

As therapy proceeded, instead of playing sadistically with animals and insects Olga became the *animal herself* and would demand paper, feathers, even leaves and branches of trees for her impersonation She was frequently a bird and could be seen trying to fly, a branch in either hand and a third fixed on behind as a tail Or she might suddenly snatch up a fur piece, a feather, or even a fur coat from an unsuspecting visitor and dash off before she could be caught. In her animal or bird role, it was evident that Olga played both *victim and attacker* Dressed in her mother's or a visitor's fur coat, she would invite the therapist to shoot her and then enveloped in fur, would lie on the floor, arms outstretched, eyes shut, and play dead but she was equally liable to leap out at the therapist, roaring like a lion (animal identification)

Still later in therapy, *human identifications* alternated with animal ones in her play, and there too, both active and passive roles were enacted. Olga's first human role was that of the baby whom the therapist must carry and feed After baby, she played mother, with her doll as the baby whom she tenderly rocked and cared for Mrs. R. reported that at home, too when Olga played mother to her dolls, she was usually the good mother of a sick child but one day when in picking up her doll its legs accidentally kicked against her, she turned to the doll in fury, threw it down, and banged its head repeatedly on the floor Mother said, 'Poor dolly is going to get hurt.' Olga stopped abruptly, looked at her mother and said very loudly, "You dropped *me* and banged *my* head, and it hurt." Only at this point did mother recall that this had actually happened when Olga was about two and a half. One day after a visit to the circus, Olga played the stunt artiste on the jungle gym, performing complicated feats of skill and demanding applause Tiring of this, she changed her role to that of ring master and shouted roughly to the therapist to bring her juice and crackers where she stood, legs astride, on top of the jungle gym Very recently Olga played another role, that of a lady, dressed up in long skirt, hat, veil, and gloves In this role she referred to herself once as 'magic' and another time as "Cinderella" She walked with a

stiff gait, holding herself rigidly as if she would break. Here she seemed to re-enact an early concept of being a jigsaw puzzle and in this manner trying to master her fear that she might break in pieces. Olga from the beginning showed anxiety about broken things particularly toys, and referred to herself many times as being broken. Once after a particularly severe rage outburst in which she had attacked the therapist, she sobbed in the therapist's arms. 'A piece fell out a piece fell out'.

CONCLUSION

We have attempted to demonstrate the significance of the emotional climate (object relationship) for personality development by giving a clinical presentation of a child who had not developed an ego capable of making the distinction between self and the outside world.

The main thesis which guided our therapeutic approach in the case of Olga R. is based on our concept of ego fragmentation as described in our previous publication where we said that when severe, chronic, overwhelming deprivation prevails, which is only rarely interrupted by instinctual gratification, the budding ego is forced to withdraw and is unable to mediate between the self and the outside world, thereby creating an arrest in the process of maturation⁽¹⁸⁾.

The chief source of deprivation is the lack of satisfactory relationship between child and mother, herself infantile and inconsistent, who adhering rigidly to book rules, is driven by guilt and anxiety rather than guided by spontaneous maternal feelings. The inhibition of her motherliness we understand as a carry over of her own early disappointing relationships which produced the forbidden unconscious fantasies regarding the child. Among the most frequently encountered and most disturbing fantasies which may exist along with the universal one of the incestuous child, are those where the mother projects onto the child the devaluated image of herself *in toto* or in part. The concept of the child being the bad self or just a piece of feces or the phallus takes on a very specific meaning and assumes such an exclusive unmodifiable significance that this in itself may be indicative of the mother's own precarious balance and lack of ego outline⁽⁵⁾. She thereby finds herself caught in a maze of ambivalent strivings seeing in her child only the projected image of herself and simultaneously, by introjecting his image, being the child. As a result of this distorted mother-child relationship the infant's capacity for differentiation of you and I is severely crippled; he does not create a core of himself, his individuality and the libido becomes invested in the self; his own body remains the sole object of love (narcissism)¹⁰.

10 This thesis of ours follows closely the Freudian concepts as validated by Hartmann, Kris and Loewenstein in their masterful presentation⁽¹²⁾. They state that with

If the basic philosophy underlying our therapeutic approach is to restore to the child the lost or undeveloped capacity to differentiate himself from the outside world and to form object relationships, we have to create an emotional climate different from the original⁽¹⁵⁾ To undo the arrest and transform it is to make restitution through the relationship with a mother substitute in the person of the therapist, who not only accepts the child at whatever level he presents himself, not making demands he cannot meet, but is capable of spontaneous feeling

In the case of Olga, we have seen the therapist, assisted by the nursery school teacher, caring for the physically well-developed four year-old child as if she were an infant, offering, so to speak, her whole body as a token of the outside world¹¹

By giving the therapeutic evolution of the case of Olga R., we have attempted to describe the ego development by minute steps and correlate it with the vicissitudes of the aggression and the libido, in order to bring clinical evidence of the key position the ego assumes as the mediator between the id and the outside world There, too, the victory of the ego over the instinctual drives was achieved by establishing various defenses, and led to progressive identifications

These identifications were most vividly portrayed in the unfolding of her play activities which not only mirrored her conflicts but enabled her to cope with and eventually to master them At first Olga identified with inanimate objects (egg beater, airplane propeller) then with animals and finally with human beings Her relationship to the therapist continues with a gradual lessening of dependency and has included adults (mother, father, nursery school teachers and others) She still however, struggles with her earlier concept of herself as a wooden jigsaw puzzle as, for example, in the re enactment of the role of Cinderella where, with stiff gait and carefully composed expression, she prevented herself from falling to pieces In this quasi heroic attempt by the child to control her body and her emotions we see the beginning of ego integration and the emergence of a personality, though still quite frail This evolution has occurred during two and a half years of therapy which will continue

the distinction between the self and the external object the *primary narcissistic cathexis* (primary narcissism) is then transformed into *object cathexis*" According to the authors Freud assumed that these processes follow a pattern established by physiological organization of *incorporation* and *ejection* the psychological counterparts are *introjection* and *projection* These intermittent changes between projection and introjection (the tendency toward and away from the human object) are the basis of the child's ambivalence (endangering the stability of the ego functions)

11 Ives Hendrick⁽¹⁵⁾ formulates that the "identification begins when a desire for a repetition of pleasure has come to be an emotional demand mentally experienced by the infant for those mother-emanating stimuli."

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RELEVANCY OF DIRECT INFANT OBSERVATION¹

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In the fifteen minutes at my disposal I had to decide between several possible approaches to our subject. The main ones are

1. A discussion of the relation between psychoanalysis and developmental psychology from the methodological point of view.

2. An extremely compressed presentation of the contributions to psychoanalysis, theoretical and clinical, by the use in my own research of developmental, psychological and experimental methods.

In view of the fact that the methodological questions can and will be discussed by others I decided for the second approach, particularly since on that question I have first hand factual information to offer. Our findings can be grouped into three categories:

1. The establishment of norms and regularities in the unfolding of the infant's mental and emotional development. Such norms have to be understood as representing broad generalizations of a statistical nature. They provide chronological age zones within which the emergence of certain behavior patterns, of certain emotional responses and of certain qualities of emotion can be expected with regularity to the point that quantitative statements about them are possible. With the establishment of such quantifiable regularities we gain a basis for comparison between various groups which is indispensable for the purpose of further scientific investigation. It could be compared to such statistical statements as the statements made about the adult human by the temperature which in the normal varies around 98.6 degrees, his pulse which varies around 72, his breathing, his chemical characteristics, etc. As you all know, such statements are not true for the single individual but provide the basis for further investigation when significant deviations from these statistically achieved figures are observed. Accordingly we will expect that, when deviations from these psychological regularities occur, they will yield information of a clinical nature.

2. Findings which are relevant for psychoanalytic theory. A not inconsiderable part of the propositions of psychoanalytic theory relate to a period in which the psychoanalytic method of free association cannot be

¹ Contribution to the Panel on "Psychoanalysis and Developmental Psychology" held at the Meeting of the American Psychoanalytic Association in Detroit on April 29, 1950.

applied as verbal communication does not exist and memories about the preverbal period are not forthcoming or unreliable. The propositions to be verified in this respect are both genetic propositions and systematic propositions. For the genetic propositions factual observations provide verification or falsification for systematic propositions the observable facts provide a better understanding. On the other hand systematic propositions can be better related to genetic propositions by the elucidation of the steps occurring in certain developmental processes. We refer in particular to processes of differentiation which are followed by integration into higher psychological units.

3 Findings and data of a clinical nature

In discussing the single headings in the light of our findings we will neglect the first one although the establishment of norms and regularities in itself has yielded an unexpected amount of information of psychoanalytic significance. We will try to include some of this information in our discussion of theoretical questions.

We will therefore proceed now to some of the findings which are relevant for psychoanalytic theory and will try to relate these findings to the different psychoanalytic propositions to which they apply. It should be understood that we are not attempting an exhaustive enumeration of our results. What we will give is more in the nature of examples of some of the more obvious results we have reached.

I

In the analytic theory the topographical viewpoint is based on the distinction of the unconscious, preconscious and conscious. The emergence of consciousness in the human being has never been investigated by psychoanalysts. A number of psychologists however have done so. They were able to prove rather conclusively that consciousness, conscious perception and memory traces connected with these do not exist at birth and in the four weeks following birth still less is there any trace of the processes of apperception. *The first signs of conscious perception and of the establishment of memory traces can be demonstrated toward the end of the second month.* Up to this point the newborn's behavior presents the picture of unco-ordinated diffuse discharge phenomena with overflow reactions. In the beginning the discharge phenomena are mainly in the nature of diffuse excitation, the counterpart of which is quiescence. A high threshold for incoming stimuli protects the newborn from overstimulation and serves as a stimulus barrier. As Hartmann suggested this may form the prototype for the later organization of the conflict free part of the ego and perhaps for defenses in the nature of repressive processes.

In the course of the first two months the development of learning

takes place according to the process of conditioned reflexes. Obviously in the beginning no objects are present. In the further development of conditioned reflex responses, part objects of a situational nature, belonging into total situations develop. During this whole period the psyche can be considered, for all practical purposes, as unstructured.

The next step in the structuration of the psyche from the topographical viewpoint appears toward the third month. At this point the first memory traces of percepts can be demonstrated experimentally. With that the psyche becomes divided into an unconscious, a preconscious and a conscious. Learning shifts from the learning according to the conditioned reflex to what I have described as "learning according to the human pattern," in which catexes are shifted on memory traces. The first objectal relations are as yet, however, in the nature of what I have called pre objects. They are characterized by containing a large proportion of situational elements and are therefore interchangeable. This progress is made only in regard to relations with human beings, not to inanimate objects where a relatively long interval, two months, will have to pass before a comparable development is achieved.

These two first stages can be considered as belonging to the narcissistic stage as described in psychoanalytic theory. Environment during the first stage exclusively and during the second stage to a great extent is perceived, experienced and reacted to not by virtue of its object qualities but primarily by virtue of the needs of the subject, the infant. Accordingly its responses are situational, that is, responses to total situations. *But while in the first stage the emotional organization varies from excitation to quiescence, in the second stage the manifestations of unpleasure and pleasure become unmistakable.* In the first stage quiescence appears to be sought and we can perhaps assign this stage to the Nirvana principle. It is a stage which appears to be more biologically than psychologically understandable. *In the second stage pleasure is sought, unpleasure avoided and the pleasure unpleasure principle has nearly unlimited sway over the infant.* However, as I have demonstrated elsewhere, for perception and mental operation to become possible the first rudiments of the reality principle, the postponement of immediate drive gratification must be established. It is at the three month period that this fateful event takes place.

It can be claimed that it is the introduction of the reality principle which accomplishes the establishment of the topographical division in the psyche. Under the action of this principle energy can be diverted from the narcissistic perceptions to the perception of the environment. With that the psyche will be divided into conscious, pre-conscious, and unconscious, and learning by experience will replace learning by conditioning.

The further development of the three systems will no longer be a qualitative one but a quantitative one. The number of memory traces will grow and ever more intricate operations will become performable on them.

II

Another systematic proposition that of the dynamic viewpoint also becomes clearly applicable at this stage. With the laying down of memory traces (which at this age are object representations) in the PCS thought processes through the displacement of cathexis have become possible. The minimal number of memory traces for such displacement to become possible is two. No proof is intended but the statement of a curious fact. Throughout the first year of life a twoness rules the development of every new behavior and activity. Two characteristics describe a perception and as I have demonstrated experimentally a new step in learning is acquired by adding one characteristic of an objectal nature and simultaneously dropping a characteristic of a situational nature. Learning proceeds thus step by step. These dynamics of cathexis displacement can be followed experimentally—and were followed by myself by Piaget and by others throughout the preverbal stage.

III

A third theory of a systematic nature which is verified in the case of our experiments is the structural theory. From what we have said before about the first two months of life no ego is present at this time. We will not discuss the question whether or not a nuclear ego is present at birth. Certainly in the sense in which we use the term—that is as a central steering organization with the tasks of defense and mastery that is adaptation—no ego is present at this time. On the basis of extensive observational material I have postulated in a monograph *The Smiling Response*(9) that *the ego level of psychic organization takes its inception in the third month*. This fits into our previous statements and is its corollary. The inception of the reality principle of the topographical division of the psyche of the capacity to manipulate cathexis of the transition from conditioned response to human learning is simultaneous with the establishment of the first rudiments of the ego. Perhaps one might be permitted to formulate all these functions as but different aspects for one and the same process. At this stage the face of the human partner has become a visual pre object with situational attributes by virtue of the infant's needs.

The further stages of ego development which I have demonstrated and which I will mention without going into the detail of our experiments and observations involve a successive expansion and solidification of the

rudimentary ego. In the next three months the situational elements which are all linked to the narcissistic stage are dispensed with one after the other. *In the third quarter the human object and also the inanimate object are recognized by virtue of their objectal attributes and perception has become truly objective. With this the period of the pre-objects has ended, and object libidinal relations have become possible.* Trite as it may seem, love is not possible as long as objects are interchangeable. *Between the seventh and eighth months the libidinal object has become firmly established and the eight-months anxiety is the sign of the infant's discrimination of its love object from all other humans.* This finding will be discussed by me in a paper illustrated in a motion picture in the further course of the Convention.

It should be mentioned in this connection that we have found in our observations that by and large in psychoanalytic writing emotions or affects are assumed as given entities. Freud described the vicissitudes of drives and the stages of libidinal development. From certain of his formulations, particularly those regarding the Nirvana Principle, the pain-pleasure principle and the reality principle it could be surmised that emotions (or affects) are not present ready-made from birth. We have succeeded in showing in some detail the successive unfolding of emotions (8). We will speak of this at some length in another paper given at this Meeting and only mention that this development also interlocks closely with the stages of ego development as well as the stages of perception and apperception. Suffice it to say at this point that through experimental psychological observation we have been able to ascertain that affective perception, emotional development, is the trail breaker for all other development of the personality in the first year of life.

IV.

The firm establishment of the conflict-free sphere(3) of the ego makes the first attempts at identification possible. In another set of experiments and observations, based on pathological material, I have been able to demonstrate phenomena showing disturbances in identification which are closely linked to disturbances in the establishment of object relations and in which spectacular damage of the ego is manifested.

The first attempts at identification become visible in the fourth quarter of the first year. They can be demonstrated experimentally in what Berta Bornstein has called "identification with the gesture." But identification of any kind can only take place on the basis of libidinal object relations after the narcissistic cathexes have been liberated for this purpose. *It is in the third quarter that narcissistic energy becomes free; this is the reason why the period between the eighth and the fifteenth*

month is a particularly vulnerable one Environmental conditions which in one way or another retard the shifting of narcissistic cathexes into neutralized libido(4) will make the formation of object relations impossible At the same time those sectors of the personality which are subject to growth and maturation(5) will continue developing A deviant pattern will thus be laid down and either force later relations into the same patterns or function to retard the normal acquisition of patterns of object relations and ego formation I have introduced the concept of developmental imbalance(7) for the description of this process which I believe is the earliest developmental psychological aspect of what Freud described as fixation points A paper under the name of Developmental Imbalance is in preparation on this problem

With this we are in the midst of findings of a clinical nature of which we will now speak very briefly

Findings of a clinical nature were predicated on the establishment of norms in the unfolding of the infant's physical and psychological personality Such norms had been investigated since the middle twenties and had been given a certain cohesion The outstanding work in this respect has been done by the schools of Ch Buehler(1) and Arnold Gesell (2) Both have used their systems for diagnostic purposes The Buehler system is by far the more useful one of the two, as it permits quantification whereas the Gesell system conveys only a general phenomenological impression Furthermore, the usage of the Gesell system was more or less confined to the establishment of organic damage The Buehler system involved more psychological categories which, however, were expressed in characterological terms Nevertheless it was the Buehler system which offered the workable transition to the clinical findings made by us Within the Buehler system the tests for the first year of life (Hetzer Wolf, 6) were those applied in our work

We began by abandoning the characterological approach and introduced nosological criteria based on psychoanalytically oriented psychiatry

With this viewpoint in mind, a number of the developmental norms established in the Buehler and Gesell systems turned out to be lacking in immediate relevancy for the understanding of the child's personality In itself it is unenlightening to find that an infant is advanced or moderately retarded in its total development It is even uninformative to establish that a given infant is moderately advanced or retarded in a single sector of its development, be that the development of bodily performance or the achievements in the I Q

This was to be expected by any informed psychoanalyst We know from school children and adults that emotional factors can raise or lower such performances They then become without any value for information

on the particular personality involved. This applies equally in the case of infants.

The criteria for normal development and conversely for the diagnosis of specific abnormal nosological pictures in infancy fall into two classes:

1 Direct criteria which are, however, mostly in the nature of necessary but not sufficient signs

2 Indirect criteria

The direct criteria are to be found in age adequate emotional responses. These obviously will be few during the first year of life. Nevertheless when we find a child lacking in the emotional responses either of pleasure or of unpleasure which are appropriate to its age we will conclude that a psychiatric abnormality is present.

The indirect signs are in the nature of proportions and relationships. As already stated above, the fact that a given child has a higher than average D Q means little or nothing. It means equally little if it is somewhat higher or lower than its contemporaries in its social response or in its manipulative ability. But if we find the child in which the social response and the manipulative ability are lowered simultaneously and are simultaneously retarded in comparison with the child's other capacities then we are confronted with the reliable sign of a definite nosological entity. We have called this picture the—S-M profile, it is typically connected with the well known picture of hyperactivity in infants and has proved to be of a certain prognostic value. From the psychoanalytic viewpoint these children show an inadequate and distorted development of their capacity to form object relations. Other such nosological entities and their clinical signs and symptoms could be established in the course of our observations. A classification of those signs and entities which have been found by us is in the course of publication under the name of 'Classification of psychosomatic diseases in infancy'.

It is obvious that such findings on infants could not be made with the help of the psychoanalytic method alone, on the other hand, the experimental psychological methods of observation, testing and statistics could not have yielded these results without the application of psychoanalytic concepts and theory.

This method of approach to infant psychiatry is new in its principle. It could perhaps be called the method of evaluating the relations between the different sectors of the personality. It is of course as yet in its beginnings and much research in the direction indicated will be needed.

On the other hand this method has yielded significant results in another direction. The relationship between such deviant pictures and the environmental factors present prior to their appearance has provided us with information regarding certain regularities in the etiology of these

pathological deviations. This approach provided us with important information regarding the environmental conditions prerequisite for the normal psychological development of infants during the different phases of the first and second year of their life. At the same time the light shed on the etiology of deviant development has made it possible to make suggestions in regard to preventive psychiatry in infancy on one hand in regard to therapeutic measures to be taken when pathology has already developed on the other. We have found these therapeutic measures singularly effective in the cases in which we have tried them.

In summing up we would say that in the case of the early stages of life where the usual psychoanalytic methods of free association and verbal communication are not applicable the experimental psychological approach used within the framework of the psychoanalytic investigation can offer valuable contributions to the psychoanalytic theory and to psychoanalytic clinic. It can never replace the exact psychoanalytic investigation of the given individual child with its whole background; it can only complement it. It can disclose certain regularities and point out the directions in which later psychoanalytic investigation of the individual may expect pathology. It will always have to look forward to the confirmation which can be offered by the ulterior psychoanalytic exploration of the same individuals who previously were experimental psychologically investigated and diagnosed. It will never achieve the richness offered by psychoanalytic research nor will it be the delicate tool in the differentiation of individuals that psychoanalysis is. But within its limits and understood in its relations to psychoanalytic theory it has valuable contributions to offer.

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COMMENTS ON THE PSYCHOANALYTIC THEORY OF THE EGO¹

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As early as in the nineties, and even before his interest had definitely shifted from physiological to psychological theory, Freud speaks of an ego, partly in a sense that foreshadows considerably later developments of ego psychology. However, the closer elaboration of this part of his work had to be postponed during a period in which his main concern was with the development of other aspects of psychoanalysis. All the revolutionary work of those years approached personality via what today we would call the study of the id. Thus, in analysis, a broad fundament of facts and hypotheses was laid down—on the laws governing unconscious mental processes, on the characteristics and development of instinctual drives and on some aspects of psychic conflict—the absence of which had been a severe handicap to preanalytic psychology. The fact that Freud's investigation of the id preceded his approach to structural psychology is indeed one of the most momentous events in the history of psychology.

When, after the time of comparative latency of his interest in the ego, Freud in the early twenties explicitly came to constitute ego psychology as a chapter of analysis, this step was made possible, and as a matter of fact imperative, by the convergence of clinical and technical as well as theoretical insight he had gained in the meantime. Today this phase in the development of ego psychology is accepted by most analysts as an integral part of their theoretical and practical thinking. It had a far reaching modifying influence also on many earlier hypotheses in other fields of analysis: e.g., technique, the theory of anxiety, or the theory of instinctual drives. Despite all this, one gets the impression that Freud himself considered his formulations of that period rather as a bold first inroad into a new territory than as a systematic presentation of ego psychology or as the last word on the structural aspects of personality. In his later papers, up to his last ones, we find modifications and reformulations the importance of which has as yet not always been realized. Some of these I shall discuss later.

¹ Read at the Convention of the American Psychoanalytic Association in Montreal May 1949.

(not the only or the earliest one) of mental self regulation in man. While speaking of the reality aspects of the ego, or of its inhibiting, or its organizing nature, etc., we are, of course, aware of the fact that its specific activities may and actually do express many of these characteristics at the same time.

With all these functions of the ego we are in continuous contact in our clinical as well as in our theoretical thinking. But it also appears that while analysts have thoroughly investigated some of them, others have only attracted their casual attention. As Freud writes 'Psychoanalysis could not study every part of the field at the same time.' Thus Freud's outline of the ego is richer in motifs and dimensions than its elaboration so far in psychoanalytic literature. Of course, there is the obvious reason that certain aspects of the ego are more specifically accessible to the psychoanalytic method than others. We have only to think of the psychology of conflict or of the psychology of defense. On the other hand, there are fields of ego functions of which one is used to think as of the exclusive domain of direct observation, or of experimental methods, though we should realize that these fields too will have to be reconsidered from the angle of psychoanalytic psychology. It is also true that certain aspects of ego psychology appear to be of greater or lesser relevance according to the context in which one views them—whether we look at them from the point of view of technique, of clinic, or of general psychological theory—the angle from which I have chosen to view the field today. Historically we notice that the study of the ego had different meanings at different times, according for instance, to the preponderance of certain technical over certain theoretical questions or vice versa. On the other hand, though it appears from his writings that he was rather opposed to considering analysis as a psychological 'system' at least in its present state, Freud unquestionably had all these aspects in mind and one of his aims, particularly in his ego-psychological work, was to constitute analysis as the basis of a general psychology. Also, the trend toward developing psychoanalytic psychology beyond its medical origin, including in its scope a growing number of aspects of normal as well as pathological behavior, is clearly inherent in ego psychology today. The techniques of adjustment to reality and of achievement emerge in a more explicit way (A. Freud 11, French, 7, 8; Hartmann, 26; Hendrick, 30 and others) and some errors in perspective that are bound to occur in viewing them from the pathological angle only can be corrected. This broader approach is also indicated, and indeed essential, wherever we use psychoanalytic propositions in so-called applied psychoanalysis, as in the vast field of encounter between analysis and the social sciences. But even the field of psychopathology proper, its clinic and its technique, have already

greatly profited from that trend in the work of Freud and many of his followers, which aims at the more comprehensive conception of analysis as a general psychology. While we know how much psychology owes to pathology, especially to the pathology of neuroses, here by means of a detour the reverse takes place

This trend should not be interpreted as a tendency away from the medical aspects of analysis or, for that matter, from its biological or physiological aspects. This deserves emphasis, because in its beginnings Freud's ego psychology was misunderstood by many, analysts and non analysts, as a parting with his original ideas on the biological foundation of analysis. Actually, the opposite comes closer to the truth, it is, in certain respects, rather a rapprochement. No doubt, the continuity with biology has, in analysis, first been established in the study of the instinctual drives. But ego psychology, by investigating more closely not only the ego's adaptive capacities, but also its 'synthetic,' 'integrating' or 'organizing' functions (Nunberg, 35, French, 9, 10, Hartmann, 27)—that is, the centralization of functional control—has extended the sphere in which a meeting of analytic with physiological, especially brain physiological, concepts may one day become possible.

In what follows I do not aspire after a systematical presentation of ego psychology. I shall select for discussion a few aspects only, and what I am aiming at is a better architectonic adjustment of some hypotheses in the field, which sometimes implies their elaboration or modification, and also their synchronization according to one level of theory formation.

Let us start with problems of ego development. Part of our hypotheses in this field rests on the solid grounds of manifold and verifiable findings of psychoanalytic clinic. However, this is unfortunately not true of the earliest stages, of the undifferentiated phase, nor is it true of those somewhat later developments that occur up to the end of the nonverbal stage. Hypotheses on these early stages can be tested as to their agreement or disagreement with the basic concepts of analytic theory, a point recently emphasized by Glover (25). Any reconstructions of this period have to beware of two dangers: of the 'adultomorphic' (Spitz) and of the 'psychosomorphic' (Hartmann) errors. Direct observation of the growing infant, especially if directed by analytically experienced observers, can prove helpful in this respect and will prove even more helpful in the future, not only by eliminating propositions which are contradicted by behavioral data (Hartmann, Glover) but also by directing the formation of hypotheses in a more positive way. I do not share the extreme skepticism of some analysts with regard to such a possibility. We shall not forget that in developing his ideas on the earliest stages of infantile development,

Freud has in many instances been guided, though not in a systematical way, by knowledge gained from other than analytic sources

Leaving questions of methodology aside for the moment, we may say that today we possess a considerable wealth of reliable and more or less systematic information, gained from many sources, about questions such as the following how the ego is being moulded under the impact of reality on the one and the instinctual drives on the other hand, in which way it learns to defend itself in both directions, and about how its development is interrelated with the development of object relationships. We also at least try to account for the development of the ego as a definite system in terms of metapsychological concepts, and, more particularly, I here want to point to the role which we think the establishment of the secondary process plays in it. We say that the ego extends from the pre-conscious memory traces. Glover(23) has tried to bridge the gap between systems of memory traces and the ego as a structural unit by introducing a hypothesis according to which a synthetization of such psychic elements as are associated with drive components takes place in nuclear ego formation. One other possible origin of ego nuclei I shall discuss later.

In trying to explain the origin of the infant's relation with reality one has heavily relied on the drive for self preservation. I should prefer a formulation which does not speak of self preservation as a result of an independent set of drives(28), but rather stresses the roles which libidinal and aggressive tendencies play in it, in addition to physiological mechanisms, and above all the role of the ego and of those autonomous preparatory stages of the ego which I shall soon discuss. We all agree that, in his development toward reality, the child has to learn to postpone gratification, the recognition, by the child, of constant and independent objects in the outside world already presupposes a certain degree of this capacity. But for the acceptance of reality also the pleasure possibilities offered by the developing ego functions are essential, as well as love and other rewards from the side of the objects and, in a later stage, gratifications due to the renunciation of instinctual satisfaction (Freud, 20).

One approach to ego development has been somewhat neglected in psychoanalytic theory, though it might hold out a promise for a more consistent integration of the analytic findings and hypotheses with the data of direct observation. Some aspects of early ego development appear in a different light if we familiarize ourselves with the thought that the ego may be more—and very likely is more—than a developmental by product of the influence of reality on instinctual drives—that it has a partly independent origin—apart from these formative influences which, of course, no analyst would want to underestimate—and that we may speak of an autonomous factor in ego development (Hartmann, 26) in the same way as we

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consider the instinctual drives autonomous agents of development. Of course, this is not to say that the ego as a definite psychic system is inborn, it rather stresses the point that the development of this system is traceable not only to the impact of reality and of the instinctual drives, but also to a set of factors that cannot be identified with either one of them. This statement also implies that not all the factors of mental development present at birth can be considered part of the id—which is, by the way, included in what I have said elsewhere in introducing the concept of an undifferentiated phase. What, in the history of psychoanalytic theory, had for a long time militated against the acceptance of this position is, above all, the fact that we were so much used to thinking in terms of "the id being older than the ego." The latter hypothesis also has an aspect which refers to phylogenesis. However, I should like to suggest that we try to reformulate it even as to this implication. I should rather say that both the ego and the id have developed, as products of differentiation, out of the matrix of animal instinct. From here, by way of differentiation, not only man's special "organ" of adaptation, the ego, has developed, but also the id, and the estrangement with reality, so characteristic of the id of the human, is an outcome of this differentiation, but by no means a direct continuation of what we know about the instincts of lower animals (Hartmann, 28). As to the ontogenetic aspect, more important for the problems under discussion here, there is no doubt, though it has not been generally realized, that Freud has come to develop his theory in a direction which modifies his previous stand, at least in one essential aspect. I am quoting from his 'Analysis Terminable or Interminable' (19) which might prove to be the most far sighted of his last papers. We have no reason to dispute the existence and importance of primal, congenital ego variations', and 'When we speak of 'archaic inheritance' we are generally thinking only of the id and apparently we assume that an ego was not existent at the beginning of the individual's life. But we must not overlook the fact that id and ego are originally one, and it does not imply a mystical overestimation of heredity if we think it credible that, even before the ego exists, its subsequent lines of development, tendencies and reactions are already determined.'

We come to see ego development as a result of three sets of factors: inherited ego characteristics (and their interaction), influences of the instinctual drives, and influences of outer reality. Of development and growth of the autonomous characteristics of the ego we may make the assumption that they take place as a result of experience (learning) but partly also of maturation—parallel to the assumption more familiar in analysis that processes of maturation intervene in the development of the sexual drives (for instance, in the sequence of libidinal organizations), and

in a somewhat different way also in the development of aggression (Hartmann, Kris and Loewenstein, 29) Keeping in mind the role of maturation in ego development may also help us to avoid one pitfall of the reconstruction of mental life in early infancy, that is, the interpretation of early psychic processes in terms of mechanisms known from much later maturational stages

The problem of maturation has a physiological aspect Speaking of this aspect we may refer to the growth of whatever we assume to be the physiological basis of those functions which, looked at from the angle of psychology, we call the ego, or we may refer to the growth of such apparatus which sooner or later come to be specifically used by the ego (e.g., the motor apparatus used in action) However, the role of these apparatus for the ego is not limited to their function as tools which the ego at a given time finds at its disposal We have to assume that differences in the timing or intensity of their growth enter into the picture of ego development as a partly independent variable e.g., the timing of the appearance of grasping or walking, of the motor aspect of speech (see also Hendrick, 30) Neither does it seem unlikely that the congenital motor equipment is among the factors which right from birth on tend to modify certain attitudes of the developing ego (Fries, 22) The presence of such factors in all aspects of the child's behavior makes them also an essential element in the development of his self-experience We can assume that from the earliest stages on the corresponding experiences are preserved in his system of memory traces We have also reasons to think that the reproduction of environmental data is very generally fused with and formed by elements of that kind e.g., the reproduction of motor experiences

Freud has repeatedly stressed the importance of the body-ego in ego development This points, on the one hand to the influence of the body image, particularly on the differentiation of the self from the object world but it also points to the fact that the functions of those organs which establish the contact with the world outside gradually come under the control of the ego The way in which the infant learns about his own body and its functions has been described as a process similar to identification (Mueller Braunschweig 34) However, it is doubtful whether this process, though leading to an integration into the ego, is actually the same as the one we have in mind when, in analysis we are referring to identification as a specific mechanism

The autonomous factors of ego development as introduced above may or may not, in the course of development remain in the non-conflictual sphere of the ego As to their relation with the drives—which does not necessarily coincide with their relation with conflict—we know from clinical experience that they may secondarily get under the influence of

the drives, as is the case in sexualization or aggressivization. To give you only one example in analysis we observe how the function of perception which has certainly an autonomous aspect, may be influenced—and frequently handicapped—by becoming the expression of oral libidinous or oral aggressive strivings. But in the context of developmental psychology, this relation with the drives has a more universal importance. In the earliest stages of development the dependence of, let us again say, perception upon situations of 'need'—and upon the drives these needs represent—is quite obvious. In these stages, then, it is clear that perception, rather generally, has to be described not only in its autonomous aspect but also as to the ways it is used by sexual and aggressive tendencies. However, the reality ego gradually evolves precisely by freeing itself from the encroachment of such instinctual tendencies. Thus what we later call sexualization (or aggressivization) may also be a problem of regression. This addition was necessary in order to make it quite clear that the autonomous nuclei, while traceable to an independent origin, constantly interact with the vicissitudes of the drives.

The autonomous factors may also come to be involved in the ego's defense against instinctual tendencies, against reality, and against the superego. So far we have in analysis mainly been dealing with the intervention of conflict in their development. But it is of considerable interest not only for developmental psychology but also for the clinic to study the converse influence too, that is the influences which a child's intelligence, his perceptual and motor equipment, his special gifts and the development of all these factors, have on the timing, the intensity, and the mode of expression of these conflicts. We know infinitely more in a systematic way, about the other aspect, the ego's development in consequence of its conflicts with the instinctual drives and with reality. I have only to remind you of the classical contribution of A. Freud (11) in this field. Here I want to touch upon but one side of this complex problem. Through what one could call a change of function, what started in a situation of conflict may secondarily become part of the non-conflictual sphere (26). Many aims, attitudes, interests, structures of the ego have originated in this way (see also G. Allport, 1). What developed as an outcome of defense against an instinctual drive may grow into a more or less independent and more or less structured function. It may come to serve different functions like adjustment, organization and so on. To give you one example every reactive character formation originating in defense against the drives will gradually take over a wealth of other functions in the framework of the ego. Because we know that the results of this development may be rather stable, or even irreversible in most normal conditions we may call such functions autonomous though in a secondary

way (in contradistinction to the primary autonomy of the ego I discussed before)

It should hardly be necessary to mention that stressing here, as I will in later passages, the independent aspects of ego functions, does not imply any undervaluation of other aspects, earlier known and more systematically studied in analysis. No doubt, if this presentation were intended to give you an over all picture of the ego, in which the space allocated to each chapter could be expected to be proportionate to its importance, the structure of my paper would have to be very different indeed. However, I may remind you of my warning in the beginning that I want to communicate to you only certain aspects of ego theory rather than its system.

There are many points concerning the origin of defense mechanisms that we have not yet come to understand. Some elements, according to Freud, may be inherited, but he of course, does not consider heredity the only factor relevant for their choice or for their development. It seems reasonable to assume that these mechanisms do not originate as defenses in the sense we use the term once the ego as a definable system has evolved (26, 4). They may originate in other areas, and in some cases these primitive processes may have served different functions, before they are secondarily used for what we specifically call defense in analysis. The problem is to trace the genetic connexions between those primordial functions and the defense mechanisms of the ego. Some of these may be modeled after some form of instinctual behavior: introjection, to give you but one example, probably exists as a form of instinct gratification before it is used in the service of defense. We will also think of how the ego can use, for defense, characteristics of the primary process, as in displacement (Anna Freud, 11). But neither the first nor the second case cover all the defense mechanisms. Others may be patterned after some autonomous preliminary stages of ego functions and after processes characteristic of the ego apparatus. I am first, thinking of the fact that these, while in the long run warranting to the child more highly differentiated and safer forms of gratification, have often also a definitely inhibitory aspect so far as the discharge of instinctual energy is concerned. This we may correlate to what A. Freud has called the primary enmity of the ego against the drives and it may be one genetic basis of later defensive actions against them. May I suggest another example. Freud has drawn a parallel between the mechanism of isolation and the normal process of attention (17). From the point of view I am stressing here, we will be interested in the question whether a genetic—not necessarily direct or simple—connection exists between the often precocious development of certain ego functions in obsessional neurosis, and the choice of this defense mechanism characteristic of it. On the other hand, Freud has often pointed to the

analogy between defense actions against the drives and the means by which the ego avoids danger from without, that is, flight and fight, about which point more will be said later. Here I want to emphasize that it seems indeed suggestive to consider very early processes in the autonomous area as fore stages of later defense against the within as well as the without. Some aspects of what may be transitional steps are well known in child psychology, as the closure of the eyelids on light which we find in neonates, definite flight reactions of no longer a merely diffuse character at the age of about four months, and other later and more specific phenomena of that kind. These reactions impress us like models of later defense. Also, in this connection, I want to point to Freud's statements about what he calls protective barrier against stimuli, in its possible relation to later ego-development. Glover(25) is right in stating that strictly speaking we cannot reduce the concept of a mechanism to simpler elements. Still, he continues, we must postulate certain innate tendencies conveyed through the id which lead to the development of mechanisms. With this, too, I can agree, as is implied in what I have said before. But I should like to draw your attention not only to those innate tendencies conveyed through the id' but also to the at least equal importance of those tendencies that do not originate in the id but in the autonomous preliminary stages of ego formation. It might well be that the ways in which infants deal with stimuli—also those functions of delaying or postponing discharge mentioned before—are later used by the ego in an active way. This active use for its own purposes of primordial forms of reaction we consider, as you know, a rather general characteristic of the developed ego. This hypothesis of a genetic correlation between individual differences in primary factors of this kind and the later defense mechanisms (apart from those correlations that we think exist of defense mechanisms with other developmental factors with the nature of the drives involved, with the danger situation etc.) is intended as an appeal to further investigation by those analysts who have the opportunities for conducting longitudinal developmental studies on children—I think that it should be accessible to direct verification or refutation.

In turning now to questions of ego cathexis, the second point I have singled out for presentation today, we are confronted with the many faceted and still puzzling problem of narcissism. Many analysts do not find it altogether easy to define the place which the concept of narcissism holds in present analytic theory. This I think, is mainly due to the fact that this concept has not been explicitly redefined in terms of Freud's later structural psychology. As to my own comments in this context I feel that I have to apologize for the particularly sketchy way in which I shall

present this particularly important problem of analytic theory I shall limit my remarks to those points only that are essential, if we want to avoid possible misunderstandings of what I want to say about ego cathexis. The reformulation of many aspects of narcissism we find in a series of searching papers by Federn (5, 6) I shall not discuss today, because in the course of his studies Federn has come to modify the concept of the ego in a way that to me does not seem altogether convincing. It seems preferable to integrate Freud's early formulations on narcissism into his later views on mental structure, rather than to change any of the main aspects of the latter.

We speak of a narcissistic type of personality, of narcissistic object choice, of a narcissistic attitude toward reality of narcissism as a topographical problem and so on. The aspects of topography and cathexis are the ones fundamental in analytic theory. In his paper "On Narcissism" (12) speaking of the relation of narcissism to autoerotism, Freud says that, while autoerotism is primordial, the ego has to develop, does not exist from the start, and that therefore something must be added to autoerotism—some new operation in the mind—in order that narcissism may come into being. Soon afterwards he stated that narcissism is the universal original condition out of which object love develops later, while even then the greatest volume of libido may yet remain in the ego (14). At the time when Freud wrote his paper "On Narcissism" just the bare outlines of structural psychology had become visible. In the following decade during which the principles of ego psychology were laid down we find a variety of formulations that I unfortunately cannot quote in detail here. In some reference is still made to the ego as the original reservoir of libido but in *The Ego and the Id* (16) Freud made it quite explicitly clear that it was not the ego but the id he had in mind when speaking of this original reservoir: the libido accrued to the ego by identification was termed "secondary narcissism." The equivalence of narcissism and libidinal cathexes of the ego was and still is widely used in psychoanalytic literature but in some passages Freud also refers to it as cathexis of one's own person of the body, or of the self. In analysis a clear distinction between the terms ego, self and personality is not always made. But a differentiation of these concepts appears essential if we try to look consistently at the problems involved in the light of Freud's structural psychology. But actually in using the term narcissism two different sets of opposites often seem to be fused into one. The one refers to the self (one's own person) in contradistinction to the object, the second to the ego (as a psychic system) in contradistinction to other substructures of personality. However, the opposite of object cathexis is not ego cathexis but cathexis of one's own person that is self-cathexis. In speaking of self-cathexis we do not imply whether this

cathexis is situated in the id, in the ego, or in the superego. This formulation takes into account that we actually do find "narcissism" in all three psychic systems, but in all of these cases there is opposition to (and reciprocity with) object cathexis. It therefore will be clarifying if we define narcissism as the libidinal cathexis not of the ego but of the self. (It might also be useful to apply the term self representation as opposed to object representation.) Often, in speaking of ego libido, what we do mean is not that this form of energy cathects the ego, but that it cathects one's own person rather than an object representation. Also in many cases where we are used to saying "libido has been withdrawn into the ego" or "object cathexis has been replaced by ego cathexis," what we actually should say is 'withdrawal on the self' in the first, and either 'by self love' or 'by a neutralized form of self cathexis' in the second case. If we want to point to the theoretically and practically important part of self cathexis being localized in the system ego, I would prefer not just to speak of 'narcissism' but of narcissistic ego cathexis.

These differences are obviously important for our insight into many aspects of structural psychology, and their consideration may help to clarify questions of catheces and their topography. Is it the turning back of the libido from the objects upon the system ego which is the source of delusions of grandeur? Or is it not rather the turning back upon the self—a process of which the accumulation of libido in the (regressed) ego is only one aspect? Neither this question in itself, nor its manifold implications I can discuss here. I shall briefly mention in what follows only one more aspect of withdrawal of libido from the objects, concerning the energetic quality of the libido involved.

In the course of that development of analytic theory which led Freud on the one hand to reformulate his ideas on the relations between anxiety and libido, and on the other hand, to constitute the ego as a system in its own rights, he also came to formulate the thesis that the ego works with desexualized libido. It has been suggested (see for instance Menninger, 33 or Hartmann, Kris, and Loewenstein, 29) that it seems reasonable and fruitful to broaden this hypothesis to include besides desexualized also desaggressivized energy in the energetic aspect of ego functions. Aggressive as well as sexual energy may be neutralized,² and in both cases this process of neutralization takes place through mediation of the ego (and probably already through its autonomous fore stages too). We assume that these neutralized energies are closer to one another than the strictly instinctual energies of the two drives. However, they may retain some of the latter's properties. Theoretical as well as clinical considerations speak in favor of

2 I use this term also used by K. Menninger rather than "sublimated," because the latter Freud has expressly reserved for desexualized libido.

assuming that there are gradations in the neutralization of these energies, that is that not all of them are neutral or indifferent in the same degree. We ought to distinguish them according to their greater or lesser closeness to drive energy, which means according to whether or not, and to what extent they still retain characteristics of sexuality (object libidinal or narcissistic) or of aggression (object or self-directed) (Freud thinks of the possibility that, in the process of sublimation object libido is first transformed into narcissistic libido in order to be then directed toward new aims. One aspect of this hypothesis is that sublimation takes place through mediation of the ego which I just mentioned. But there is also another implication which, however, I do not intend to discuss here.)

To be able to neutralize considerable amounts of instinctual energy may well be an indication of ego strength. I also want to mention at least the clinically well-established fact that the ego's capacity for neutralization is partly dependent on the degree of a more instinctual cathexis being vested in the self. The degree of neutralization is also another point we have to consider—besides those mentioned before—if we are to describe adequately the transition from the narcissistic state of the ego to its later reality-syntonic functioning. Furthermore the ego's energies relative closeness to the drives may also become a decisive factor in pathology. To take again an example from the field of narcissism. It is of paramount importance for our understanding of the various forms of "withdrawal of libido from reality" in terms of their effects on ego functions to see clearly whether the part of the resulting self-cathexes localized in the ego is still close to sexuality or has undergone a thorough process of neutralization. An increase in the ego's neutralized cathexes is not likely to cause pathological phenomena but its being swamped by insufficiently neutralized instinctual energy may have this effect (under certain conditions). In this connection the ego's capacity for neutralization becomes relevant and in the cases of pathological development the degree to which this capacity has been interfered with as a consequence of ego regression. What I just said about the bearing of neutralization on the outcome of libido withdrawal is equally true where not libidinal but aggressive cathexes are being turned back from the objects upon the self and in part upon the ego. In the case in which aggression is turned back we will of course likewise always have to consider the superego's proclivity to use certain gradations of aggressive energy. These instances of the role of neutralization in the functioning of the ego I choose at random out of many. Another one I shall discuss more in detail soon.

The question whether all energy at the disposal of the ego originates in the instinctual drives I am not prepared to answer. Freud thinks that "nearly all of the energy active in the psychic apparatus comes from the

drives, thus pointing to the possibility that part of it may have a different origin. But what other sources of mental energy may there be? Several possible answers come to mind but obviously this question is hard to decide in the present state of our knowledge. It may be that some of it originates in what I described before as the autonomous ego. However, all these questions referring to the primordial origin of mental energy lead ultimately back to physiology, also of course in the case of instinctual energy, and our factual insight and conceptual tools make a positive answer to the question of possible noninstinctual sources as difficult to ascertain as a negative one.

We return to the ego. Regardless of whether its energetic aspect be wholly or only partly traceable to the instinctual drives, we assume that once it is formed it disposes of independent psychic energy, which is just to restate in other terms the character of the ego as a separate psychic system. This is not meant to imply that at any given time the process of transformation of instinctual into neutralized energy comes to an end, this is a continuous process. The ego's energy is available for the great variety of ego functions I mentioned before. In this connection I want to add that many of the ego's tendencies which express these functions are object directed, that is not narcissistic in the sense that they take the self as their object, nor are all of them narcissistic in the sense that they only work with the different gradations of this special form of psychic energy.

In speaking of various shades of desexualization or desaggressivization one has to think of two different aspects. One may refer to different modes or conditions of energy, and this energetic aspect of neutralization may partly coincide with the replacement of the primary by the secondary process, which allows of any number of transitional states. We are used to consider the secondary process as a specific characteristic of the ego but this does neither exclude the use, by the ego, of the primary process, nor the existence, in the ego, of differences in the degree to which energies are bound.³ The second angle from which we have to consider those shades of neutralization is the degree to which certain other characteristics of the drives (e.g., their direction, their aims) are still demonstrable (neutralization with respect to the aims).

Let us now look again, this time from the point of view of cathexes, at the psychology of defense and take as our point of departure a crude schematization of a typical case: preconscious cathexis is withdrawn and the ego defends itself through anticathexis against the reappearance of the instinctual tendency. According to one hypothesis of Freud (13), the energy which is used in the formation of counter-cathexis is the same—or may be the same—which has been withdrawn from the drives. Nun

³ See also E. Kris (31, 32) Rapaport (38)

berg(36) cites this process as a particularly good example of the economic nature of psychic organization. In analytic literature, countercaathexis is, as a rule, said to consist of desexualized libido. However, most of these formulations belong into a period of analytic theory formation in which aggression had not yet been recognized as a primary and independent drive. Today we would assume that countercaathexis may equally well consist of neutralized aggressive energy. According to Freud's hypothesis this would be the case, whenever the warded off drive is an aggressive one [another part of the warded-off aggression finds its expression in feelings of guilt (Freud, 18)]. But Freud's hypothesis of the energy of countercaathexis being withdrawn from the drives is not necessarily meant to be generally valid, "it is quite possible that it is so," is what he once says in this connection.

Other considerations suggest the possibility that the role of more or less neutralized aggressive energy in countercaathexis may be of an even more general nature and greater relevance.⁴ I again remind you of the analogy pointed out by Freud between defense against the instinctual drives and against an external danger. The two processes involved in the schematic example of defense just outlined make such a parallel very impressive indeed. flight and fight can be said to be its main characteristics, withdrawal of caathexis corresponding to flight and countercaathexis to fight. This leads to the answer I want to suggest here that the latter widely uses one of those conditions of more or less neutralized aggressive energy, mentioned before, which still retain some characteristics of the original drive (fight, in this case). It seems not unlikely that such forms of energy—it is not necessary to assume that all countercaathexes operate with the same degree of neutralization—contribute to countercaathexis even if the warded-off drive was not of an aggressive nature.

To assume that the ego uses for defense only and always energy withdrawn from the drives against which it defends itself does not agree too well with what we know today about the high degree of activity and plasticity characteristic of the ego's choice of means to its ends. Also, it seems of the greatest interest to consider what interdependence there exists between the defensive functions of the ego and other ego functions. There is no doubt, and I mentioned it before, that defense is actually genetically and dynamically under the influence of other processes in the ego and, on the other hand, that defense intervenes in a great variety of different processes in the ego, this I discussed as an essential side of developmental psychology. We have to assume that this interdependence has also an energetic aspect, and this, too, leads to the conclusion that, although coun-

⁴ I want to mention that after having formulated this proposition I found a somewhat similar idea in a paper by M. Brierley(5).

tercathexis may draw on energies withdrawn from the warded off drive—and I shall later discuss one case in question—this is not the *only* source of energy at its disposal

At this point I want to remind you of another one of those later hypotheses of Freud's (19), of which I said that their importance for our theoretical thinking has not yet been clearly realized. It points to the possibility that the disposition to conflict may be traced (among other factors) to the intervention of free aggression. Freud, in introducing this thought, gives examples of instinctual rather than of structural conflicts (if we use these terms in the meaning suggested by Alexander). But he adds that it confronts us with the question whether this notion should not be extended to apply to other instances of conflict or indeed whether we ought not to review all our knowledge of psychical conflict from this new angle. This disposition to conflict, traceable to aggression, would come into play independently of the nature of the drive against which defense is directed. On Freud's idea we may base what I just said about counter-cathexis being fed by neutralized aggressive energy—if we assume for the case of conflict between the ego and the drives that the aggressive energy is (more or less) being bound in the service of the ego's defensive actions. This hypothesis seems more consistent both with what we know about the ego today and with Freud's later thinking than other propositions on counter-cathexis based on his earlier concept formation.

We may look at the same problem from another angle. In the same paper, Freud describes how, in working on our patients' resistances, we meet what he calls resistance against the uncovering of resistances, and mentions the well-known fact that in this situation phenomena of negative transference may come to predominate. Is it not possible that meta-psychologically speaking part of this aggression directed against the analyst is re-aggressivized energy of the counter-cathexes mobilized as a consequence of our attack on the patient's resistance? This again would well agree with the proposition under discussion.

Before leaving this subject I want to call to notice one more implication, though being aware of the somewhat speculative character of this inference. *Vis à vis* an external danger an aggressive response is normal while sexualization may lead into pathology. If the defensive reaction against danger from within is modeled after the one to danger from without, it is possible that there too the use of—in this case more or less neutralized—aggressive energy is more regular than the use of desexualized libido. This might also mean that in case of defense against an instinctual danger, a place for aggression would more easily be found in the defensive reaction of the ego itself (in counter-cathexis) while the danger they represent and other factors being equal, more of the energy

of the libidinous strivings, which could not as easily be disposed of this way, would have to be repressed (or warded off in another way) To come back to an earlier point I would assume that the use, in counterathesis, of energy withdrawn from the drives, is more general if they are of an aggressive than if they are of a libidinous nature I realize, of course, the sketchy character of this statement, and also that I am simplifying what is actually a highly intricate process However, this hypothesis, of which I do not dare to decide whether or not it will prove to be correct, might be helpful (if integrated with others on the subject that have already been accepted in our analytic thinking) toward explaining the etiological predominance of sexual over aggressive factors in neurosis

A systematic study of ego functions would have to describe them as to their aims (for the difference between "aims" of drives and "aims" of the ego, see Hartmann, 27) and as to the means they use in pursuing them, energetically as to the closeness to or remoteness from the drives of the energies with which they operate, and also as to the degree of structuralization and independence they have achieved Here I want to say a few words only about one special group of ego tendencies as an example of which Freud discusses 'egoism' (14) Their importance was, of course, fully realized by Freud, and it would seem desirable to assign them a definite place in psychoanalytic psychology, but, their position was never clearly defined on the level of structural psychology, though Freud had tried to account for them on an earlier level of theory formation At that time, Freud identified the self preservative tendencies with "ego drives," and the cathexes proceeding from them he called 'interests,' in contradistinction to the libido of the sexual drives However, of 'drives of the ego' in the strict sense we do not speak any more today, since all the drives were realized to be part of the system id (see also E. Bibring, 2), this change in theory necessitates a reformulation also as to the phenomena Freud had in mind in speaking of 'interests' Among the self preservative psychic tendencies we think functions of the system ego to be of foremost importance (21, 27)—which is not to say of course that sexual and aggressive id tendencies some aspects of the principles of regulation etc., have no part in self preservation The group of tendencies which comprises strivings for what is 'useful,' egoism, self assertion, etc., it seems reasonable to attribute to the system ego Among the factors of motivation they contribute a layer of their own The importance of these tendencies has been somewhat neglected in analysis probably because they play no essential part in the etiology of neurosis and because in our work with patients we have to consider them more from the angle of genetically underlying id tendencies than in their partly independent

aspect as functions of the ego. But the relevance of this latter aspect becomes obvious the moment we turn to viewing them from the angle of general psychology, which is what I am doing here, or of social science. Social science no doubt falls short of its aims as long as it bases its interpretation of human behavior exclusively on the model of the interest directed, we may here say "utilitarian," type of action. On the other hand, many fields of social science are practically unapproachable to analysis as long as we disregard this layer of motivation.

What position can we attribute to these interests in present analytic theory? May I first suggest that we term these and similar tendencies 'ego interests,' thus retaining the Freudian name but also implying that we consider that part of what he called 'interests' which we have in mind here as belonging to the system ego. They are interests of the ego; their goals are set by the ego, in contradistinction to aims of the id or of the superego. But the special set of tendencies I am referring to is also characterized by the fact that their aims center around one's own person (self). I may add that this is true of their aims only. They obviously also use or serve ego functions that are directed toward the outer world and, among the factors which lead to the change, by man of external reality, ego interests of this kind play unquestionably a decisive role.

One should beware of overemphasizing terminological questions in this field so little known to us. It might prove practical to include into the concept of ego interests, besides this one, other groups of ego tendencies of an otherwise similar nature, the aims of which do not center around the self—for instance those which affect the outer world not only indirectly, in the sense just outlined, but whose aims are centered around other persons or around things, or those which are striving toward aims originating in the superego but taken over by the ego, that center around values (ethical values, values of truth, religious values, etc.) and finally also interests of the ego in mental functioning itself (as for intellectual activity) might be included.

These ego interests are hardly ever unconscious, in the technical sense, as are, among the ego functions, in the typical case, the defenses. They are mostly preconscious and may be conscious—but sometimes we meet difficulties in bringing them into consciousness. This often seems to be so because of their closeness to id tendencies underlying them, but I would not dare to decide whether this is always the case. At any rate, we will remember what Freud(13) stated about a censorship working not only between the preconscious and unconscious, but also between the conscious and the preconscious mind. The existence of the latter teaches us, according to Freud, that becoming conscious is probably due to hypercathexis—a further advance in the mental organization. The

genetic connection of the ego interests with id tendencies is often obvious, even more often it is established by analysis. However, this development is often not reversible, except under special conditions (through analysis, in dreams, in neurosis, etc.) They do not follow the laws of the id but of the ego. They are working with neutralized energy and may, as is often the case, f.l. with "egoism," put this energy against the satisfaction of instinctual drives.

Strivings for wealth, for social prestige, or for what is considered "useful" in another sense, are genetically partly determined by anal, urethral, narcissistic, exhibitionistic, aggressive, etc., id tendencies, and either continue in modified form the directions of these drives or are the results of reactions against them. Obviously, various id tendencies may contribute to the formation of one specific ego interest, and the same id tendency may contribute to the formation of several of them. They are also determined by the superego, by different areas of ego functions by other ego interests by a person's relation with reality, by his modes of thinking or by his synthetic capacities etc., and the ego is in a certain measure able to achieve a compromise in which the instinctual elements are used for its own aims.⁵ The source of the neutralized energy with which the ego interests operate seems not to be confined to the energy of those instinctual strivings out of which or against which they have developed. Other neutralized energy may be at their disposal. This is actually implied in thinking of them as sharing the characteristics of the ego as a functionally and energetically partly independent system. We may state that many of them (in different degrees) appear to belong to the field of secondary autonomy. As to the comparative dynamic efficacy of the ego interests what we know about their energetic aspects is too small a basis for any definite conclusion.

The self-directed ego interests—egoism striving for what is considered useful etc.—we find in various relations of collaboration with but also antagonism against other ego functions. That the type of action directed by them should not be confounded with "rational action" I have pointed to elsewhere (27). They are interacting with object-centered ego tendencies, with that level of self-regulation we call the organizing function with adjustment to reality and with other functions. We do not know too much about what form of structural hierarchy of ego functions is most likely to be found correlated with mental health in a positive way. But one point I should like to emphasize is that the subordination under this group of ego interests of the other ego functions is no criterion of mental health (though it has often been said that the capacity to sub-

⁵ For the categories of problems to the solution of which the ego is consecrated see Waelder (39).

ordinate other tendencies to what is considered "useful" makes the difference between healthy and neurotic behavior). These ego interests are, after all, only one set of ego functions amongst others and they do not coincide with those, closer correlated with health, that also integrate the demands of the other psychic systems (synthetic or organizing function).

I have mentioned ego functions opposing each other. Because these contests are clinically not of the same relevance as those between the ego and the id, or the ego and reality, etc., we are not used to thinking of them in terms of conflict. However, we may well describe them as intrasystemic conflicts and thus distinguish them from those other, better-known conflicts that we may designate as intersystemic. The intrasystemic correlations and conflicts in the ego have hardly ever been consistently studied. A case in question are, of course, the relations between defense and the autonomous functions which I mentioned before. To the question of communication or lack of communication between different areas of the ego, which is to the purpose here, I may also quote Freud's statement that the defenses are, in a sense, set apart in the ego. Contrasts in the ego there are many: the ego has from its start the tendency to oppose the drives, but one of its main functions is also to help them toward gratification; it is a place where insight is gained, but also of rationalization; it promotes objective knowledge of reality, but at the same time, by way of identification and social adjustment, takes over in the course of its development the conventional prejudices of the environment; it pursues its independent aims, but it is also characteristic of it to consider the demands of the other substructures of personality, etc. Of course it is true that ego functions have some general characteristics in common, some of which I mentioned today, and which distinguish them, *f.i.*, from the id functions. But many misunderstandings and unclarities are traceable to the fact that we have not yet trained ourselves to consider the ego from an intrasystemic point of view. One speaks of "the ego" as being rational, or realistic, or an integrator, while actually these are characteristics of one or the other of its functions only.

The intrasystemic approach becomes essential if we want to clarify concepts like "dominance of the ego," "ego control," or "ego strength." All these terms are highly ambiguous, unless we add a differential consideration of the ego functions actually involved in the situations we want to describe. It is not possible for me really to go into the much written-about matter of ego strength here (see Glover, 24; Nunberg, 37) and a few remarks only will have to suffice in this connection. We are used to judging the strength of the ego on the basis of its behaving in typical situations—whether they arise from the side of the id, of the superego, or of outer reality. This would imply that ego strength, like adaptation,

can be formulated in terms of a set of relations only. We may think of this as a parallel to many physiological problems: in cardiac failure, incapacity of the heart may be due to great and sudden exertion, or to reasons residing in the organ itself, it may also be due to the state of affairs in the blood vessels, and these factors are again interdependent with central regulations and other variables in this complex system. Strength or weakness of the ego—whether habitual or occasional—have been traced to many factors belonging to the id or the superego, and it was pointed out that they are exclusively due to the degree to which the ego is or is not encroached upon by the other systems (Glover). However, I may say here that also the autonomous aspect of the ego has to be considered. The discussion of a great variety of elements which one has tried to correlate with the degrees of ego strength—like the strength of the drives, narcissism, tolerance or intolerance against unpleasure, anxiety, guilt feelings, etc.—still leaves us with some confusion. Also, as Nunberg said, the answers are valid only for some, narrowly circumscribed, situations. One typical instance of the difficulties involved, to which attention was drawn by Freud, is the well known fact that defense, while demonstrating relative strength of the ego vis à vis the drives, may, on the other hand, become the very reason of ego weakness. We have to admit—again like in the case of adaptation—that it seems rather generally true that achievement in one direction may cause disturbance in others. In the context of today's paper, I just want to emphasize one approach to the problem. I mean the one of carefully studying the interrelations between the different areas of ego functions like defense, organization and the area of autonomy. Whether defense leads to exhaustion of the ego's strength is not only determined by the force of the drive in question and by the defenses at the ego's frontiers but also by the supplies the hinterland can put at its disposal. No definition of ego strength will prove satisfactory that considers the relations to the other psychic systems only and is not intrasystemic in the sense outlined. Any definition will have to include as an essential element the consideration of the autonomous functions of the ego of their interdependence and their structural hierarchy, and especially of whether or how far they are able to withstand impairment through the processes of defense. This is unquestionably one of the main elements of what we mean in speaking of ego strength. It is probably not only a question of the amount and distribution of ego energy available, but also has to be correlated with the degree to which the cathexes of these functions are neutralized.

Taking as my main points of departure some of Freud's later and not yet fully integrated findings, I presented to you today a mixture, and I am sure not always successful synthesis, of synchronizations and re

formulations of and additions to some generally accepted tenets of psychoanalytic theory. May I end by quoting a passage from Freud's writings(17): "Let us not grudge the effort necessary for such emendations, they are desirable if they enhance our understanding a little, and no discredit if they do not negate our previous conceptions but enrich them, perhaps make a generality more specific or broaden a conception which was too narrow"

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EGO-PSYCHOLOGICAL IMPLICATIONS OF THE PSYCHOANALYTIC TREATMENT OF DELINQUENTS

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It is generally agreed upon that the psychoanalytic technique as broadly outlined by Freud in his technical papers is applicable only to some of those psychogenic disorders which belong to the group of the psychoneuroses.

For certain groups of disorders other techniques had to be devised since it became apparent that they were not amenable to the technique which so well served the treatment of the psychoneuroses. There are mainly three groups of disorders for which separate techniques have been worked out: the disorders of childhood, the group of schizophrenias, and the delinquencies. It was inevitable that the evolving of new techniques should raise the question whether or not they met the requirements of psychoanalysis. Paul Federn has discussed in general terms the conditions which a technique must fulfill in order to be considered a psychoanalytic technique⁽²⁾. Here I wish to add a purely pragmatic statement. I would suggest that Freud's technique, for apparent reasons, should be considered as a kind of model treatment and that deviations necessary for the purpose of extending the range of psychoanalytic treatment to disorders outside of the neuroses should be kept at a minimum. For the sake of convenience the degree of deviation will be called the parameter of that technique. Consequently that technique which, e.g., in the treatment of the delinquencies, achieves its purpose with the smallest possible parameter, should be given the preference among all others and should be called psychoanalytic, although, as is the case of the treatment of delinquents, the deviation necessary at times may be so great that the model technique which it tries to approximate may scarcely be recognizable. But, speaking again pragmatically, if a change of technique is necessary, it should be shown each time why the model technique would be considered ineffective in the respective clinical instance and why the parameter of the new technique cannot be reduced. The psychoanalytic treatment of the neurotic varies from patient to patient, according to his neurosis and the individual facets of the patient's personality, and Freud's broad outline was meant only as a delimitation of an area, so to speak, within

which the psychoanalytic technique should move. The following suggestions, based mainly on the technique evolved by Aichhorn (whom I quote with all due reservation because of the possibility of having misunderstood him) can, of course, only indicate a broad principle which must be adapted to the individual necessities of each patient. When one speaks in general terms of the psychoanalytic technique of the delinquent's treatment, this is never meant as a rule to be relied on but only as something to be kept in the back of one's mind in order to avert a sudden discontinuance of the delinquent's treatment. In other words, it may be beneficial to have a frame of reference which may help us to understand why the classical technique, if tried with a delinquent, does not lead to the expected success.

Furthermore, in this discussion I would suggest a change in the definition of the concept of transference. Freud has given a specific meaning to the concept. In what follows I will use the term in places which may seem not to fit Freud's definition in all respects. I therefore suggest a pragmatic definition which goes somewhat beyond the scope of Freud's definition insofar as it includes all emotional prerequisites which the patient should acquire in order to carry out his part of the psychoanalytic treatment. This short statement must suffice to justify the subsequent use of terms such as the creation of transference.

The treatment of delinquents differs so much from that of neurotic patients because it falls into two phases which, although they gradually merge and overlap for long stretches, nevertheless are each significant of differences in therapeutic aims and also in the basic dynamic relationship between analyst and patient.¹ For reasons to be clarified later, I have collected experiences mainly about the first phase which I want to call the *initial or preparatory phase*.

Another factor may impede the discussion of psychoanalytic technique, particularly of the technique used in disorders which do not belong to the psychoneuroses. I refer to the danger of the analyst's personal biases and predilections influencing the choice of technique. Although this is a factor also to be considered in discussions of the technique of the treatment of neuroses, the impact of a personal factor on the parameter in the treatment of delinquents may have serious consequences. Whereas a genuine interest and curiosity in psychological matters and the therapist's personal analysis are, broadly speaking, the main prerequisites for the psychoanalyst's treatment of neuroses, these are not sufficient for the treatment of schizophrenics, and particularly not for that of delinquents. At present, I think, one cannot yet define what these pre-

1 The necessity of starting the treatment of a patient by using a technique deviating significantly from that in the subsequent phase also occurs in the treatment of certain neurotic types. See Greenacre(8).

requisites are, but certainly they are intimately connected with the stratification of the deepest conflicts in the therapist's own personality or, in other words, with the structure of the relations between his ego, id and superego

In the following presentation I wish to mention only three points which, I think, are indispensable in the treatment of delinquents, but certainly do not cover all its problems. As Aichhorn has emphasized in his technical papers, the main goal in the initial phase of the treatment of delinquents concerns the establishment of the delinquent's transference to the analyst. The structure of the neuroses is such as to make the development of transference an almost automatic process if the technical situation is handled correctly. The neurotic has a particularly strong tendency to establish a transference. In dealing with neurotic disorders, the main duty of the analyst concerns only the interpretation and adequate distribution of the patient's transference. But the predominantly narcissistic quality of the delinquent's personality, his incapacity of loving or of turning with positive feelings toward a partner and the consequent absence of any spontaneous positive transference reaction, make it necessary that the analyst provoke or create the patient's positive transference by active measures. Although, as mentioned before, the resulting relationship does not necessarily deserve to be called transference, since it is not identical with that emotional reaction in the neuroses, it plays a dynamically similar role in the delinquent's analysis. Furthermore, this emotional relationship between the analyst and the delinquent, laboriously built up during the initial phase, becomes in all aspects more and more similar to the neurotic's transference the closer the treatment approaches the second phase and finally the two are indistinguishable.

It has been my repeated experience that the delinquent patient will establish a workable emotional relationship with the analyst only after he has experienced the analyst as an omnipotent being. Furthermore, he must be convinced that the analyst is determined to use his omnipotence for the patient's benefit and will never be tempted to use his quasi-super natural forces for the patient's displeasure in spite of all provocations to which the patient may expose him. Let me illustrate this point with a clinical example. This will make it easier to add some theoretical suggestions in regard to this necessity, peculiar to the treatment of delinquents, of having to act temporarily like an omnipotent being.²

I

A seventeen and a half year old girl was sent into analysis because of promiscuity, frequent alcoholic bouts and repeated failures at college. She was an

² See Hoffer (9 p. 150f) for the role which omnipotence plays in the treatment of a certain type of delinquents.

attractive looking young woman whose intelligence and artistic talents were above average. Her family background was a typical New England one. She had lost her father at the age of seven and had a younger sister who was born shortly after her father's death. Both parents had a high scholastic standing and as a young child the patient had shown promising intellectual talents. Nevertheless she had gone through high school with great difficulties and had failed at college scholastically as well as in her social conduct. Her mother was finally advised to send her daughter into analysis. The patient agreed to try out that suggestion since she herself was afraid of complete failure. I shall not elaborate on the dynamic description of her disorder but rather emphasize the clinical aspect. The first interview showed that the technique which we commonly initiate with a neurotic would not have carried the analysis to any success in her case. After having given me a broad outline of her difficulties she somewhat abruptly assured me that she would do everything in her power to seduce me and that she was practically certain she would be successful. Furthermore she let me know that if she were to fail which to her was inconceivable she would feel so unhappy that she would be incapable of continuing her treatment.

With this statement she showed how little she was really interested in straightening out her difficulties and to what extent she was determined to make the treatment another opportunity for continuing her delinquent behavior. The analysis of neurotics regularly shows that the neurotic's desire to be freed of his symptoms is counterbalanced by at least an equally strong, but often even stronger, unconscious desire to maintain his neurotic symptom. But the conscious desire for treatment, however much based on pretense, is an indispensable prerequisite for the application of the classical analytic technique. This patient, however, in the first interview did not even pretend to want to be cured in order to acquire mastery over her sexual impulses which had caused her so much pain and disappointment in the past. Instead, she frankly declared that her main interest was to repeat the very behavior which analysis was expected to cure. Later attempts to make the patient talk about her problems in a situation of free association confirmed the impression I had obtained in the first interview, namely, that the patient was utterly incapable of following her free associations. When asked of what she was thinking, she regularly responded with the reply that nothing went through her mind. Here again we encounter an essential difference with the behavior of neurotics in psychoanalytic treatment. The neurotic quickly responds to the suggestion that he report the sequence of his ideational stream. He will co-operate with evasions, resistances and subterfuges, but he will provide the analyst with a wealth of data which can be interpreted. To the delinquent, however, the situation of free association is alien or incongruous. It bores him and he is incapable of respond

ing to it in any way which could be put to a constructive use in terms of a psychoanalytic treatment. Therefore it would have been futile to insist on this procedure with this patient.

In the first and many subsequent interviews therapy was limited to conversations of a seemingly trivial nature. We discussed her professional plans, her difficulties in finding adequate living quarters, her worries about her college work and many other problems of her everyday life. Early in the treatment the patient tried to arouse censure by provocative behavior. The first time she told me that she had been picked up the previous night by a man and had had intercourse with him, she had been sure that I would react with moral disapproval and she was taken by surprise that I could listen to this report of her conduct with equanimity.

I gave the patient the best advice at my command in all situations in which she felt worried. As far as her sexual and alcoholic escapades were concerned, I emphasized that I thought it would be to her interest if she could avoid them, since it seemed that the pleasure she obtained was not in proportion to the grief she subsequently suffered and the injuries she had caused herself in the past. But I assured her that I understood very well that she was incapable of mastering these impulses at present and tried to prevail on her to attempt to gratify them in such a way as to reduce the self-destructiveness to an unavoidable minimum. I succeeded in manipulating the situation successfully to the extent that the patient's delinquent behavior did not interfere with her scholastic work. But it became evident that the patient created situations of increasing difficulties which threatened to overtax my ingenuity. At times she would telephone in the middle of the night to ask me what to do because she had got drunk. Usually I was able to break through her muddled sentimental conversation and to persuade her to end her drinking bout and to go home. Sometimes it happened that I had to go to a bar and take her home because it had become evident over the phone that she was unable to take care of herself.

The following incident occurred which actually threatened to destroy completely the therapeutic relationship. In the fifth month of her treatment it happened that she told me in the middle of the night of a desperate situation into which she had gotten herself. In the evening she had gone to a night club which she knew was frequented by lesbians. She had picked up a drunken, horrible-looking lesbian and had taken her to her room where the woman had immediately fallen into a deep sleep. After a few hours when the patient tried to make her leave, the stranger began to swear and refused to go. The patient was horrified because soon everyone in the building would get up and if the lesbian girl were discovered in her room, either the police would be called or a telegram sent to her mother who lived out of town. The patient ended with the remark that she did not know why she had called me at all since I had no way of helping her. In her opinion the situation was final and irreparable. Under ordinary circumstances it certainly would not have been difficult for me to go to her room and to persuade the drunken woman to leave. In fact, I would probably have been more successful in dealing with the drunken woman than the patient who was

frightened and guilt ridden. However the patient lived in a building which men were not permitted to enter not even in a professional capacity. I had to admit to myself that she really had won a victory over my therapeutic endeavors and that she had managed in an uncanny way to create a situation which seemed to be a Gordian knot. To gain time and hoping that it was only my drowsiness which made me feel so pessimistic I gave her some superficial advice about how to talk to the drunken woman. Since it was evident that the patient was trying to prove my inability to solve her problems I was convinced that her renewed attempts would be unsuccessful. She promised to try once more and to call me back. After a few minutes of reflection it dawned on me that there might after all be a possibility of repairing even that desperate situation. I called a social worker with whom I was acquainted and asked her whether she would be ready to help me in this emergency. When the patient called me she was taken aback when I told her not to be upset because I was certain that I could soon help her. I asked her to wait for me in front of the building and half an hour later she and the social worker went to her room. It was not difficult for a professionally trained person to get the woman out of the building and the whole incident had no untoward repercussions. From the point of view of the patient's treatment however that incident had remarkable consequences. Following that episode she stopped drinking and no further incident of promiscuity occurred. She became attached to a young man and the only outward manifestation which from the point of view of present society could be called delinquent was her living with the young man in a kind of common law marriage. Of course this miraculous symptomatic change did not mean that the structure of the patient's personality had been changed in any respect. Her inability to establish healthy relationships with other people her depersonalization her inability to express her emotions all remained untouched. However the fact that she stopped indulging in delinquent behavior brought her immeasurably closer to a situation in which her problems could be subjected to analytic treatment. From that time on the necessity for practical advice and guidance by me was reduced to a minimum and work on her psychopathology came more and more into the foreground of her interviews. Concomitantly anxiety began to replace her previous delinquent behavior. Her symptomatology became increasingly reminiscent of that of a neurosis. Her increased toleration of anxiety without immediate escape into aggressive behavior brought her closer to a state in which she would be accessible to the model technique of psychoanalytic treatment.

It is necessary to get an appropriate understanding of what had enabled this patient to relinquish suddenly the several serious symptoms of delinquency which had persisted for many years. In my opinion the patient was convinced when she called me that night that she was making me face a situation which could not be repaired in spite of all the efforts I would be ready to make and that she would thus prove to her satisfaction the grave limitations of my power to help her. The fact that in spite of her ingenious planning I could solve the practical aspect of that problem left her with the impression that whatever the future compli-

cations of her life should be, I would be strong enough to give her protection sufficient to maintain her survival and well being. The amazing consequence of that supreme test was that the patient felt no further desire to test my ingenuity and consequently was able, by and large, to conform to the principles of conduct accepted by the social group to which she belonged.

A similar sequence of events could be observed in those types of delinquents with whom I had an opportunity to get in closer contact. A workable relationship between analyst and patient, manifested by the abatement of acute symptoms, was always achieved only after the patient had temporarily accepted the analyst as an omnipotent but benign being. Since I never obtained, either from the patient just described nor from other such patients, any childhood history adequate to explain these transference reactions, I can only speculate as to the possible reasons for their regularity.

A comprehensive psychopathology of the feeling of omnipotence has not yet been written, but it seems to me that the problem of omnipotence must be viewed under a variety of aspects. With a slight extension of the literal meaning of the term, one may speak of the omnipotence of instincts. The dream, to a certain extent, is a regular submission of the ego to the indestructible power of repressed drives. Instinctual gratifications may cause the ego to feel omnipotent. The ego so to speak, then borrows from the indestructible power of somatic urges, and in the process of making itself the willing tool of passions, it achieves gratifications far beyond the realm of instinctual pleasure.

The superego also plays a significant role by its perennial insistence on omnipotence. A reflection of this is encountered in the claim of religions and ethics to the eternal and indubitable validity of their value systems. External reality also is varyingly experienced as an unassailable and unchangeable omnipotent force, and the ego itself, even under normal conditions harbors to a certain extent the claim to omnipotence. Indeed, one may say that a certain kind of feeling of omnipotence is necessary for a person's well being.

In another place I will present the case history of a patient who actually achieved great success in reality on the basis of a feeling of omnipotence which, however, in his case could not be called normal. His omnipotent feeling ceased its beneficial effect when he suffered his first major defeat in life. But what we ordinarily call the healthy optimism of the well balanced person probably has its roots in an unconscious feeling of omnipotence which permits the ego to overcome defeat and danger by virtue of the conviction that future times will prove the ego to be victorious.³

3 See Freud's remark on success and optimism (4 5 6). See also Angel (1).

In the type of delinquency discussed in this paper, one encounters a noteworthy pathology of the feeling of omnipotence. These patients are sometimes exposed to an amazingly quick succession of feelings of omnipotence and of extreme inferiority. At times they will be quite unaware of any danger surrounding them or of the possibly harmful consequences of their actions. At such times they will act as if they had no need of any of the precautions indispensable to others for their survival. Occasionally they openly claim that they are exempt from the necessity of heeding the laws the average person abides by.⁴ At other times they will be convinced that they are not strong enough to endure any kind of pain, effort or disappointment and will behave like helpless infants. Of course, both behavior patterns originate from the closeness of their psychic processes to the pleasure principle. I conclude from these symptoms that the trauma, or series of traumata, which have initiated the severe pathology of their ego structure, must have occurred at a time when the child's early feelings of omnipotence were one of its main tools in dealing with reality. From the observation of children it is known that during a certain phase the child not only feels himself omnipotent, but readily attributes such powers to persons of his environment, to animals, or even to inanimate objects. These patients must sometimes have had a disastrous experience in a situation in which they expected protection, help, or love from the persons whom they had endowed with omnipotent powers. This trauma may have kept the child fixated to the phase of omnipotence which apparently prevented the ego from reaching higher developmental levels. Such patients, at times, experience their environment as extremely hostile and they must mobilize their feelings of omnipotence in order to counteract the expected aggression. The quick succession of feeling immune to any attack, followed by the feeling of complete helplessness, reflects the early traumatic situation when the child tried to counteract the inroad of the omnipotent forces by using his own omnipotence against the supposed adversary—only to fail. The predominantly hostile coloring which the environment takes on for them makes these patients quite frequently appear paranoid, but their history and their clinical symptomatology make it possible to differentiate them from their schizophrenic counterparts. Their frequent fear of impending destruction is due to the fixation to an early phase when any danger meant the imminence of total destruc-

4 I remember the first time I was puzzled by such a claim. Many years ago in Alchhorn's Guidance Clinic I was assigned the task of persuading a young man of nineteen to agree to a physical examination. He had lived for many months with a girl who suffered from syphilis. Nevertheless he refused to go to a clinic when told to by the social worker. When I met him he seriously claimed that he was sure he could not become infected. When it turned out that he was not infected he accepted the information as a foregone conclusion and did not show the slightest sign of pleasurable surprise.

tion They are evidently unable to differentiate dangers and, when anxiety is stimulated, it is prone to develop into a panic. Their defense against the emergence of panic is aggressive behavior. As children they apparently were prevented from experiencing their parents as benign, helpful and protective authorities. This happened even when the parents were not negligent or particularly aggressive toward them, but an early trauma may have prevented them from ever developing the feeling of confidence and trust in parental authority. If we can rely on certain observations, I would suggest hypothetically that the particularly disastrous effect of the early trauma may have been due to the fact that it occurred at a moment when the child was in extremely pleasurable tension and expected a particular gratification. When then an unpleasant stimulus reached the child, it may have had a far greater shock effect than if the same stimulus occurred at a time when the child's expectation was not aroused or was neutral. The effect of the trauma depends greatly on the child's emotional condition at the time of the trauma's occurrence. Unfortunately parents are often irritable and tense just when the child is also irritable and tense. This happens most often when the child is sick. Sickness in children is always correlated with a condition in which the child's ego is also weakened and therefore needs additional support and affection. But sickness, particularly in the young child, makes parents worried, fearful, pessimistic and irritable. Therefore it happens not infrequently that relatively unambivalent parents inadvertently traumatize the young child by not realizing that sickness itself produces in the child an acute need for his parents' devotion.⁵

In the afore-mentioned patient's history I obtained some vague information about a trip to the West combined with a temporary physical disease in the baby and an alarming chronic disease in the father. The mother reported that after that trip the child's behavior changed. But the analytic investigation never reached that depth which would have been necessary to find out for certain what the traumatic event really was during that trip which changed a genuinely friendly baby into a child whose favorite game was to imitate animals and to bark and bite people who approached her in a friendly fashion.

If we apply this short theoretical digression to the earlier reported clinical observations of the effect of benign authority during the analytic treatment, one may draw the following conclusion. As soon as the analyst has been put into the position of authority in his relationship with the delinquent, the patient recreates a situation which comes quite close to the essentials of the early traumatic childhood constellation. If the patient is carried through that potentially traumatic situation without being exposed to the reoccurrence of a trauma, the injury which he obtained in

5 See Anna Freud and Dorothy T. Burlingham (3)

the early childhood situation loses its compelling effect on his behavior. In other words, if the adult ego has repeated opportunities of reliving a situation somewhat similar to the early traumatic situation, without suffering a repetition of the trauma, it may enable the ego to abstain temporarily from aggressive behavior. However, the effect of that therapeutic measure is selective. Even though the patient has already discontinued the acute delinquent manifestations by virtue of his transference, he, nevertheless, still will regularly show acute aggressive reactions in the presence of those persons to whom the memories of traumatic experiences are attached or to their close substitutes.

The mechanism underlying this therapeutic situation may be somewhat related to that of the traumatic neuroses, as described by Freud, where subsequent nightmares serve the purpose of undoing the harmful effect of traumata by virtue of their repetition in the dream, accompanied by an adequate development of the anxiety which was lacking when the patient suffered the trauma. The delinquent patients apparently must go through situations in which, potentially, the original trauma could recur. But the repeated experience that, in spite of all prerequisites necessary for the recurrence of the event, the traumatic event does not take place, leads to a step which they really should have taken at an earlier age, namely, to trust authority which in their minds is omnipotent, to integrate the idea that such authorities may be benign to them.

Perhaps we must also view this situation under another aspect. In the course of his development the child transfers more and more of his own feelings of omnipotence to persons of his environment. This process is comparable to the transformation of primary narcissism into secondary, as Freud described it. The gradual shifting of omnipotence feelings facilitates the child's recognition that others have powers greater than his own. The delinquent's pathology seems to be focused around the conversion of the primary feeling of omnipotence into secondary. He resists giving up some of his own omnipotence to others. The trauma must have occurred at a time when the child was on the verge of relinquishing the position of primary feeling of omnipotence. Thus during the initial phases of treatment, the analyst becomes the object to which the patient attaches the secondary feeling of omnipotence. The degree to which this can be accomplished will be one of the factors determining the prognosis of the treatment. It must be the analyst's aim to intensify these processes to the maximal capacity of the patient's tolerance. It must be emphasized once more that this process does not occur spontaneously as does the transference of most neurotic patients under adequate conditions, but that it requires a consistent stream of activity on the analyst's part.

My comment on the delinquent's psychopathology regarding feelings

of omnipotence may appear contradictory in view of what I have said about his spells of infantile helplessness. However, this seeming contradiction may be dissolved if we assume the delinquent's psychopathology to be the result of a trauma and that it concerns a severely injured feeling of omnipotence. The partly compensatory character of the delinquent's pathology must not be overlooked. Moreover, I did not include a discussion of the delinquent's feeling of guilt which is a variable and is sometimes extensive and sometimes small. The psychopathology centering around the maintenance of a feeling of omnipotence, however, is, I think, a constant factor in delinquent patients.

II

Another indispensable element in any inventory of the psychoanalytic treatment of delinquents concerns the new and the familiar. I think that the role which the new versus the familiar plays in the psychopathology of many disorders has not yet been studied sufficiently. To be sure, in the majority of neurotic patients one does not encounter any particular manifestations of this problem but it seems to me that in two groups of disorders, the problem makes its appearance in distinctive forms. My observations have led me to feel that for the delinquent only the new has a positive emotional value, whereas he cannot enjoy what is familiar and is, more often than not, bored by it. In schizophrenic patients I have observed just the opposite tendency namely that experiences significant because of their quality of newness are rejected and usually precipitate a pathological reaction. The schizophrenic feels at ease and frequently reacts with the disappearance of acute symptoms when he finds himself in situations which are completely devoid of novelty and completely familiar to him. This is not the place to discuss the possible consequences which this fact may have on the metapsychology of schizophrenia. Instead I wish to emphasize that in this context the terms new and familiar do not refer to objective attributes of the patient's environment but merely describe the qualities of the patient's subjective experiences. A schizophrenic may suddenly feel that he is seeing his mother for the first time, while a delinquent may go through a situation which is nearly identical with a previous one and nevertheless claim to have enjoyed it as new, enticing and surprising. To be sure usually these qualities of newness and familiarity can be correlated to some objective factors in the external situation but their main sources stem from the subjective meanings which the patients attach to these situations.

The delinquent is, by and large, constantly driven towards experiencing the unknown. Partly, this is responsible for the restlessness and unreliability, so frequently encountered in delinquents. A large number of

them will start work successfully but very quickly feel bored as soon as the new work situation has lost its character of newness, it becomes devoid of interest. The uninteresting and boring, however, are repugnant to the delinquent. Their great sensitivity to boredom may be connected with problems regarding death. It looks as if a state of boredom to them were the same as a harbinger of death.

Patients showing any serious degree of delinquency usually suffer from a pathological attitude towards death. They are continually preparing themselves against being overwhelmed by death. However, I shall not elaborate here on this interesting disturbance regarding the representation of death and of time. The delinquent seems to become more easily bored than the average person and therefore he must expose himself to stimulation seemingly greater in intensity and variety than the average person needs in order to maintain a feeling of well being.

Since the element of surprise is one of the effects which most reliably indicates to a person that he is in a new or unforeseen situation it is necessary, in order to make a delinquent emotionally interested in the treatment, to provide him consistently with situations of surprise.⁶ Preferably these surprises should be pleasurably colored, but the delinquent prefers even a mildly unpleasant surprise to a situation of constant familiarity. The necessity of keeping him stimulated by surprise is one of the greatest difficulties in his treatment. It puts a continuous demand on the analyst's ingenuity and resourcefulness. As long as the analyst behaves in accordance with the delinquent's expectation—that is e.g. as long as he behaves as a physician is expected to behave in our society—the delinquent will have only little interest in the therapeutic situation. Therefore it is important to institute a technique of surprise as quickly as possible, even in the first interview. We know that a first impression often has a more lasting significance than the later impressions received in the course of longer acquaintance. The whole course of an interpersonal relationship may be decided at the first moment of becoming acquainted. The earlier the delinquent is given an opportunity of experiencing the analyst's presence as something entirely new, unforeseen and surprising, the greater is the hope that the delinquent's treatment will take an effective course. I want to give an example of the way in which the surprise element may be introduced into the treatment.

A twenty five year-old gambler was referred for treatment. He had gambled impulsively since the age of twelve and repeatedly destroyed some promising professional situations by indulging in extremely self-destructive gambling bouts. Later in the treatment it turned out that the patient suffered from a severely

6 The experience of surprise is discussed here in a different context than that used by Reik(10) who made an extensive study of this phenomenon.

disturbed attitude toward work and from an inability to maintain an adequate relationship with other people. His sexual life had been devoid of activity; he had never had intercourse, nor did he remember ever having masturbated. The patient's severe anxieties, hypochondriacal fears and compulsions which emerged later in the treatment will not be described here.

When in the first interview he told me that for a short while he had been treated by another psychiatrist, I asked him what that colleague's recommendations had been. He told me that his first psychiatrist had advised his parents that he must never be given any money in order to deprive him of any opportunity to give in to his urges. I replied that I did not believe in such a treatment and that I would have to insist that his father give him an annual amount of money for the express purpose of being used for gambling. I informed him that in my experience for those who do it consistently gambling was an important outlet which if suddenly and entirely blocked leads to a severe aggravation of their condition. In order not to endanger his health I was therefore compelled to recommend for him an opportunity to gratify moderately a desire which if left ungratified might lead to untoward effects. However I added it seemed only fair to his father that the patient determine the minimum figure which he needed as gambling capital and that he make it a self-imposed rule never to go beyond the amount he had set himself.

The patient certainly had not foreseen such a turn in his first interview. Furthermore I was practically certain that he had never met any one who would take such an attitude toward his gambling. Unavoidably I must have become in that moment a person of interest to him, a person about whom he wanted to know more, a person who did not fit into any of his preconceived images of people in respectable professions. At the same time my attitude may have led to a temporary devaluation of his symptom, since money prescribed by a physician for a medical purpose can no longer have the great emotional importance he had previously attached to money robbed from his father for the purpose of being wasted in gambling bouts.

How to organize the course of a treatment in order consistently to take the delinquent by surprise and never to permit him to make correct guesses about the future behavior of the therapist is a matter which depends entirely on the requirements of the therapeutic situation and which can never be defined in general terms. Moreover what situations the patient will find new and surprising also varies in accordance with his background and the individual facets of his psychopathology. All this puts the greatest demand on the analyst's therapeutic acumen. There is no doubt that the delinquent's treatment is continually threatened by an abrupt discontinuance as long as life promises the patient more frequent and more intensive experiences of newness and surprise than the analyst's office. Since this point again brings up an element of technique which is

always necessary in the treatment of preponderantly delinquent patients, we are here faced with the question—why must these elements of surprise be continuously provided?

Anna Freud has recently reported on sleeping disturbances in infants.^{6a} These disturbances which occur earlier and with greater regularity than one would have anticipated she explains by virtue of some constant factors in a phase of ego development. At a time of accelerated ego development it seems that the child has great difficulty in letting go of his activities. He cannot easily get rid of his waking personality and may be afraid of losing that which he has recently acquired. I would like to paraphrase Anna Freud's description of that phase of the child's ego development and ask whether perhaps the child, in encountering certain experiences for the first time—whether they be situations or activation of functions—reacts with a kind of ecstatic joy. In other words, may it be assumed that when a child for the first time becomes aware of certain activities or certain experiences it is fascinated by the newness of these psychic processes? The child may then feel attached to those processes with such intensity that he does not want to part with them and therefore can only fall asleep with difficulty. The effect of this experience on the child's sleep has no bearing in this context. But if there is a phase in the child's development in which the quality of newness plays a great role in the child's psychic life this may contribute a hypothetical explanation of the great role which newness plays in the psychic life of the delinquent. It could be possible that for an as yet unknown reason, the delinquent is fixated to that developmental phase, and tries to recapture the pleasure and fascination which the growing child would experience more or less continuously during a certain phase of early development. However tempting such an assumption may be a scrutiny of those experiences which a delinquent describes as new and surprising and therefore fascinating reveal that the problem must be more complicated. We usually find when listening to a delinquent's enraptured reports of his pleasures which as he assumes are unknown in the monotonous and boring world of the non-delinquent that what he describes as new and surprising is really a repetition of one and the same experience. It then turns out that the delinquent in reality experiences the old and familiar content under the mask of the new and surprising. One might say that the schizophrenic looks for the new under the cloak of the familiar whereas the delinquent experiences the familiar under the mask of the new. This involves a mechanism similar to the one described as underlying the experience of the uncanny. It seems that the delinquent must reassure himself that that which may strike him as new and surprising is in reality something fa-

familiar Hence it is possible that in his persistent search for the new and surprising (which in reality covers up the monotonous repetition of identical experiences) the delinquent is trying to defend himself against the potential recurrence of a trauma By endowing the familiar with the quality of the new he actually escapes the experience of a truly new situation which he seems to equate with the traumatic

In conjunction with the new and the familiar I want to call attention to a developmental problem of which I think only little is known and which seems extremely difficult to investigate There is a phase in the child's development which can be called the discovery of the ego Comparable to the phase in which the child discovers that there is an outer world and familiarizes himself with it there must be a developmental phase in which the child discovers that he is he which means that there is not only an outer world but also an ego as a distinct entity

Whereas up to then the child had taken his existence for granted without a distinct experience of self and without noticing that categories such as a beginning and ending have a place in his own life in the new phase the attention directed towards the outer reality now rebounds onto himself It is probable that the child discovers the outer world and conquers the outer world by projecting himself into external reality Yet that phase does not necessarily correspond to the child's becoming aware of his own personality In the little clinical material I could collect it seems that the child discovers and takes possession first of the outer world by projection and that only subsequently experiences take place whose content leads to awareness of one's self One hears little about that phase in analysis Only from two female patients did I obtain reports of remembering experiences in which they became aware for the first time that they were they These experiences certainly were accompanied by surprise and the recognition that they were they was a great discovery to them In both instances the situation implied that the discovery of the ego occurred in conjunction with masturbation and a conflict about the lack of a penis However I know little about the meaning of these episodes in terms of the patients' later ego pathology because their analyses were prematurely discontinued for external reasons I had a doubt throughout the treatment of both patients as to whether analysis would be able to cure them

It is possible that in a normal development the discovery of the outer world and of the child's own ego run parallel to the extent that a step in the direction towards reality is followed by a step in taking cognizance of the ego or that both occur concomitantly It is conceivable that in normal development external reality becomes a distinct experience to the child only in the measure that he simultaneously makes a correlated progress

in the discovery of his ego. I could imagine that in the two female patients, just mentioned, I was dealing with a pathological ego development insofar as the two phases—namely, the discovery of external reality and the discovery of the ego—had occurred one after the other instead of simultaneously and that this was the reason why they had preserved distinct recollections of the latter.

On the other hand, I could imagine that the child's gradual awareness of external reality preoccupies his mind to such an extent that a corresponding process regarding the child's own ego can only set in belatedly. Be this as it may, experiences regarding the self, accompanied by the feeling of newness and surprise have far-reaching consequences. It will have a great bearing on the clinical outcome whether these experiences, particularly at their first occurrence, concern the total ego, part of the ego, the body or part of the body. A patient remembered that an early experience of this type was due to a sudden abdominal cramp. He could not remember ever having had a similar feeling of that sort before. He screamed in terror because he was unable to foresee what intensity the pain might reach. The fact that he became aware of his body under such dramatic conditions had a deep effect on the development of his body image, and on his hypochondriacal fears, and contributed to his compulsive preoccupation with the inside of his body. I do not mean to intimate that this patient had never had abdominal cramps before, but the sensation acquired its great psychological importance because it became the subject of early awareness. I am convinced that many problems which now are puzzling will become better understandable when consciousness is differentiated from awareness. The difference between consciousness and awareness can at times be noticed in the following situation. The mere repetition of a patient's words by the analyst may have a stupendous effect. The words repeated by the analyst were contents of the patient's conscious mind, but when the patient hears the same words spoken by the analyst, a new quality is introduced. The patient may suddenly become aware of what he really has said. In a similar way the initial experiences, in which the child takes cognizance of his own ego and by virtue of which he no longer can take his own existence for granted, may form an important nucleus contributing to the adult's psychopathology. Whether the child later as an adult will, under stress, develop a neurosis, psychosis or delinquency, may depend on the conditions under which he discovered his ego, and on the time at which it took place.

If this conception is applied to the particulars of the delinquent's psychopathology one must conclude that a traumatic interference made him regress from the phase of ego discovery to the previous one in which the internal conflict was mainly manifested in his relationship with ex-

ternal reality. The prognosis of the patient's disorder may then depend on the extent to which he had made progress in the direction of taking cognizance of his ego before he reverted to his previous exclusive interest in external reality, or whether he had ever reached that phase at all. The delinquent, no doubt, suffers from a deficiency in the capacity of observing himself. The frequent reply that he is not thinking of anything when pressed for a verbalization of his associations is not always only a resistance, but often the consequence of really lacking awareness regarding the contents of his stream of consciousness. The delinquent finds himself nearly constantly in a frame of mind which everyone experiences occasionally. We all at times may be unable to remember or to reconstruct what our ideational contents were during the last few minutes although we were certainly not asleep. It usually concerns a brief period of time in which the conscious stream of thought was not accompanied by awareness. The delinquent's deficiency in developing awareness of internal psychic processes, his constant preoccupation—almost like an addiction—with sectors of external reality, his inability to tear himself away from external reality and to direct his attention towards himself, make me believe that genetically part of his psychopathology is rooted in that early transition period between the time when the child was mainly occupied in taking possession of reality and the time when he discovered his own ego.

Consequently the delinquent's striving towards a new and surprising content in external reality is also a defense against the emergence of a new and surprising internal content. He does not want to expose himself once more to a traumatic experience which he incurred when he was on the verge of discovering his ego. The great role which the new plays in the delinquent's psychopathology may help explain a recurrent observation. In most studies on the psychopathic personality it is claimed that the psychopath⁷ is unable to learn from his life experiences. As far as the delinquent is concerned I think the claim is exaggerated. Delinquents learn very well; only they do it in fields where society—and their environment—would prefer their not learning anything new. The psychopath or delinquent respectively appears incapable of learning in some sectors of his life. This incapacity is restricted to certain fields. It is true the situations affected by this incapacity are the most important ones as far as their survival as members of their social groups is concerned. In order to learn a person must recognize a situation as familiar, i.e. as having occurred before. Since the delinquent refuses to grant the quality of famili-

7 I shall not discuss here my objections to the clinical validity of the term psychopath. The claim that the so-called psychopath is incapable of learning has however a place in this context.

arity to certain situations, in spite of their repetitive character, his capacity for learning must often appear stunted. This apparent deficiency is secondary, however, and is a consequence of his addiction to novelty. Once he grants the familiar its proper place he shows no greater incapacity to learn than do other patients.

III

In the course of the initial treatment period one encounters another obstacle which is prone to complicate the technique of that phase. In the treatment of female as well as of male delinquents, their tendency to accept only the concrete part of external reality as valid and valuable becomes noticeable. This tendency shows up differently in men and in women. It is a rather rare exception to find a male delinquent who does not labor under the conviction that only the receipt of money is a definite proof that he is loved. Any kind of positive manifestation, the expression of affection and friendship by words or deeds, are meaningless to him unless the person proves the sincerity of his feelings by parting with money and giving it to him. The analogous situation in the treatment of female delinquents concerns their conviction, as far as I could see, that only a man who loves them sexually has positive feelings toward them. The mere fact that a man does not show any desire to engage in a sexual experience with them, gives them the feeling of being rejected, or even hated. Friendship, based on feelings of nonsexual affection, is unknown to them and cannot be accepted as a dependable tie between them and others. Although they have repeatedly proven that their sexual relationships end in disaster, they will nevertheless operate on the same principle over and over again. Since in their lives sexual intercourse is simultaneously a direct consequence of and a prerequisite for maintaining a positive relationship, their promiscuity is a necessary consequence of sustaining positive attitudes. Receiving money in the case of the male and promiscuity in the case of the female delinquent are indispensable to these patients, because they mean far more to them than appears on the surface. If the male delinquent needed money solely for the purpose of providing himself with the satisfaction of a need, or the delinquent girl desired intercourse merely for the purpose of gratifying her sexual wishes, the therapeutic task would be relatively easy. But in both instances money and intercourse are the patients' sole means of obtaining the feeling of being in contact with the world, of being loved and of loving. The aggressive meaning of such attitudes becomes evident in the course of treatment. It is a repetition of oral attitudes frequently observed in children when mother's love is measured in quantities of food. Situations of rivalry bring this characteristic conspicuously to the fore. Some children feel neglected

and unloved as long as they do not obtain more food from mother than their siblings. Delinquents are unaware of sacrifices made for them as long as these sacrifices are not expressed in a concrete substance which they can incorporate. The tendency toward concreteness is mainly based on oral fixation and is also the result of the comparative deficiency in the ability to sublimate which is significant of so many delinquents. Why in reducing the meaningful to the concrete the delinquents favor money and intercourse as adequate media will not be discussed.

The consequences of this tendency are different in the treatment of male and female delinquents. I have never yet treated a male delinquent in the course of whose treatment it did not at some time become necessary to give him money. Not until he had received money was he able to develop the positive feelings toward the analyst which made the further course of therapy possible. The therapeutic necessity of giving money to a delinquent patient requires technical skill and tact and usually some general principles must be heeded otherwise no benefit will ensue. The analyst must never make the giving of money a routine matter because then he becomes in the delinquent's eyes a person of whom he can take advantage just as he does with others outside the analytic situation. It must be given at a time when the delinquent did not expect it that is under circumstances in which the delinquent will be taken by surprise. Furthermore the money must be given without any conditions being attached to the gift. If any moralistic or prohibitive request is combined with it the delinquent gets the impression that the money is not given to him because he is loved but for a certain purpose and that of course would defeat the object of the whole action. It is the unqualified surrender of part of the analyst's omnipotence which makes it possible for the delinquent temporarily to accept the analyst as a benign authority. He must never be under the impression that giving concrete support required an effort on the analyst's part because he would interpret that as concealed hostility. Nor must the concrete support be given in a situation in which the delinquent thinks he has pressured the analyst into surrendering money. If he thinks he was able to force the giving he will interpret the analyst's help as weakness. The situation of giving and taking must be kept free of any implication that hostility may have been involved in either the patient or the analyst. If concrete support is not to arouse feelings of guilt in the patient nor to degenerate into exploitation of the analyst it must be so given as to conform to the imagery of a mother who gives freely from her abundant supply and who gives her love and care to her infant whenever it needs it without counting the effort or expecting a return beyond the infant's healthy growth and well being. In his treatment probably for the first time in his life the delinquent has the ex-

perience of obtaining something he is ardently striving for without a corresponding decrease in the omnipotence of the person who is ready to share an advantage with him. This is essentially in contrast to all his previous experiences when he succeeded in obtaining money from a person by request, threat, blackmail or embezzlement, which meant to him depriving an adversary of a potent and powerful medium.⁸

The desire for concreteness which manifests itself in the life of the male delinquent by his incessant wish for money can be fulfilled in the terms he desires, but the corresponding situation in the treatment of the female delinquent is more difficult since physical contact of any kind is utterly incompatible with psychoanalysis. However, there are ways of using the exclusive importance which physical contact plays in the life of the female delinquent for the aims of the initial treatment phase. As I mentioned before, the delinquent woman discussed at the beginning of this paper declared in the first interview that she would try everything in her power to seduce me. She later assured me of being certain that I was in love with her and would like to start an affair. She felt puzzled because I did not follow up my desires by corresponding actions in order to profit from her willingness. If a comparable situation occurred in the analysis of a neurotic woman, the analytic procedure would immediately focus on the patient's fantasy and try to dissolve it by showing her that it belongs to a repetition of earlier experiences and by interpreting the transference character of the patient's feelings. The neglect of properly analyzing the fantasy in a neurosis would soon lead to a standstill of the analysis or its discontinuance. But analysis of this fantasy, during the initial phase of the treatment of the female delinquent, would lead to quite a different result. An interpretation of this kind would either not affect the patient's conviction or would possibly compel her to discontinue the treatment. The patient can bear the continuance of the treatment only under the assumption that the analyst harbors sexual desires for her since this is the only concept she is able to form of a man's positive attitude toward her. I purposely did not do anything to destroy the patient's belief in this respect but tried to convince her that, in view of the great harm she had suffered in the past by virtue of her promiscuity, there was not the slightest reason to believe that a new sexual relationship would result in a benefit to her. Therefore, since I was determined to help her straighten out the very difficult situation in which she was, I would not follow up her invitation to start an affair. However, I always agreed that she was

8 To be sure, in the course of treatment all these conditions must be changed. Depending on the severity of the patient's disorder some of the conditions enumerated here may be neglected. I have purposely chosen extremes in this context.

charming and attractive and assured her that an affair with her would be pleasurable

The fact that I never made advances to her, although her fantasy pictured me as being ardently in love with her, became a valuable therapeutic support because she was surprised to see that a person, even when driven by a strong desire, as she assumed could master his wishes for her sake. I think that the patient's conviction and fantasies about me helped her in curbing her tendencies toward promiscuity. It may seem to be paradoxical that in the male the gratification of his desire for money, but in the female the refusal of a gratification should have a similar therapeutic effect. However, the patient's previous experiences must be considered. The male has observed that people do not want to give him money or do it only reluctantly, the female delinquent that every man she wanted to seduce followed her wishes only too gladly. Since the analytic situation must be constructed in such a way that it never coincides with one of external reality, it becomes evident why in one instance, gratification and in the other, refusal result in the patient's improvement. Moreover, the beneficial effect which the illusion of being loved has on the female patient, in spite of lacking gratification proves that her promiscuity was due not only to sexual impulsiveness but also was the expression of her limitation in finding any meaning in life beyond the concrete.⁹

Concreteness certainly plays a greater role in the mental life of the child than in the life of the adult¹⁰ and here it is not necessary to go into details regarding the discussion of this well known phenomenon in the child's life. Yet it may still be necessary to stress that the tendency towards concreteness which I have described as significant of the delinquent's psychopathology is no index of the delinquent's intellectual endowment. One finds all grades of intelligence among delinquents and an impairment of abstract thinking is by no means characteristic of the syndrome. But only the concrete becomes emotionally meaningful to him. Depending on the severity of the disorder, this may extend to all sectors of his life or be limited but it always shows up in close emotional relationships. I believe that this symptom is the most difficult task to cure in the treatment of delinquents.

⁹ Further discussion of the reasons for the beneficial effect of this technique would lead to the sexual problems of this type of delinquent girl which would transcend the scope of this paper. It may be said only that the patient's aggression regularly turned against those men who had complied with her wishes. This sequence of course brought forth some fundamental conflict regarding her seemingly strong heterosexual desires.

¹⁰ See e.g. Werner(11)

IV

Undoubtedly the foregoing technical suggestions show that the treatment of the delinquent has a great parameter. Almost all of the technical moves are diametrically opposed to what is the accepted technique in the treatment of the neuroses, and I have tried to show why, nevertheless, they are indispensable and cannot be further approximated to the model technique. I chose severe disorders intentionally. In mild cases of delinquency so great a parameter will never be necessary and for some of them the model technique may be the proper one. But I hope that I have made it clear that my remarks refer exclusively to the initial phase. The great parameter of the delinquent's treatment is necessary because his personality must first undergo a reorganization which will later permit an analysis proper, conducted according to the model technique. Interpretation plays a minor role during the initial phase and must be given only if it serves the goal of preparing for the second phase. The clinical index of having reached the end of the first phase is the patient's freedom from delinquent symptoms, i.e. the patient must have shown his capacity to bear up under the stresses of daily life without falling back into delinquent symptoms. Furthermore, he must have shown sufficient positive attachment to the analyst to make it probable that he will be able to tolerate the unavoidable displeasure and discomfort of the model technique, without running away from analysis or retaliating by aggressive behavior. In the second phase analysis proper can be instituted. But it must be stressed that, if the treatment cannot be successfully carried through the second phase, one should not consider the patient's treatment a full analysis.

The utmost the first phase can accomplish is the abatement of manifest delinquent symptoms and the gradual replacement of aggression by anxiety or other neurotic symptomatology. This may not be necessarily considered by the patient as a therapeutic gain, but it is the unavoidable intermediate clinical phase before the disorder proper can be attacked. When the second treatment phase is reached, the treatment technique approximates more and more the model technique and should become nearly identical with it. Therefore a special discussion of it is unnecessary. It can be said that the treatment of the delinquent starts with the greatest parameter and gradually switches to a technique whose parameter is increasingly reduced until it reaches zero under optimal conditions. The conceptual differentiation between the preparatory and second phase, of course, does not show up clinically to the same degree because, as mentioned before, there is an overlap of phases.

However, here again I must report experiences which may make the reader question the clinical soundness of this technique. It happened

regularly that when I had reached the goal of the initial phase of the treatment and the patient showed all the signs indicating that he was ready to start what I have just called analysis proper, I did not succeed in making the patient accept a technique which was so different from that of the initial phase. In other words the patient's behavior both in and outside of analysis made it evident that he had reached the point where he could bear the discomfort of the model technique, that he had acquired the capacity of tolerating the unavoidable frustrations which the model technique imposes on the patient, yet, nevertheless, he did not fit himself into the requirements of the new treatment phase. Such a situation is therapeutically sterile. The analyst must no longer provide the patient with the gratifications which he previously gave profusely since, by doing so now, he would only be preventing the patient from using his recently acquired therapeutic gain. The patient appears to be unable to make use of the kind of benefit which the second treatment phase is providing. Thus the treatment comes to a standstill. It seems as if the patient cannot forget the pleasures he obtained in bygone days from his analyst and refuses to submit to the pain of frustration caused by the same person about whom he has so many pleasurable associations. When the treatment reaches such a period of lull, one has to persuade the patient to agree to a change of analyst. It usually turns out that the patient can accept frustrations from the new therapist. If this happens without the necessity of a repetition of the first phase—i.e., when the patient behaves in the new treatment situation as one is accustomed to seeing neurotic patients behave—then one can be assured that the initial phase has been a therapeutic success and not an unnecessary detour. Furthermore it proves that the initial phase, in spite of its great parameter, is a legitimate part of the psychoanalysis of delinquents. The mere fact that a change of analyst becomes necessary does not preclude the claim that the first part of the treatment had been a therapeutic success—a success however, of little value if not supplemented by the continuance of the treatment with another analyst. I wish to add that Aichhorn claimed to have been able to carry a delinquent patient through both treatment phases. The switch from the initial or preparatory phase to proper psychoanalysis however, demands so much technical acumen that it cannot be expected to be at the command of the average analyst. It is perhaps worthwhile to mention that the treatment of schizophrenics also falls into two different phases. However, with schizophrenic patients there is usually no difficulty in their making the transition from one phase to the next, and no change of analyst becomes necessary.

The danger points of the technique in the preparatory phase, as outlined here are, of course, numerous. I want to mention only two. This

technique, if not carefully planned and properly executed, may precipitate acting out. It may, if rashly applied, stimulate the delinquent's unbridled surrender to his symptoms, thus making the patient ridicule the analyst by persiflage. Furthermore, it may lead to the analyst's exploitation. Then the therapist becomes the easy prey of the delinquent's aggressive impulses, and the whole treatment degenerates into one in which the patient's only interest lies in finding ways of obtaining more and greater favors from the analyst.¹¹ Finally, the patient's symptoms may involve more sacrifices than the analyst is capable of or willing to make.

It is clear that the treatment of the delinquent imposes particular difficulties on the therapist. Small wonder that there is a tendency toward pessimism in regard to the therapeutic prospects of the delinquent, commonly called a psychopath. It is not evident why the treatment of the delinquent should require so much more skill than that of other psychogenic disorders. In my experience, the schizophrenic patient has a better chance of obtaining proper therapy than the delinquent. It is interesting to speculate why it is relatively easier to analyze a schizophrenic patient than a delinquent. The delinquent's psychopathology, roughly speaking, concerns the under-development of his superego, whereas the schizophrenic's psychopathology concerns functions of a much earlier developmental stage. One would expect it to be easier to identify with a patient whose pathology concerns later developmental structures than with a patient whose psychopathology takes place within the framework of basic functions. As clinical experience shows, there are several reasons why in general it is easier for the therapist to understand the psychopathology of the schizophrenic and to find his way through the difficulties of his treatment than to do so with the delinquent. The schizophrenic pathology seems accessible to empathy since dreams have become understandable. Our own dreams teach us the way a schizophrenic experiences the world, and the understanding of our own dreams enables us to share the schizophrenic's psychic experiences through empathy. Identification with the schizophrenic therefore seems to be facilitated, since his daily world is part of our conscious experience at night time, whereas the life of the delinquent, let us hope, is not part of the analyst's memories. Moreover, in many instances, identification with the delinquent seems to harbor more danger than the corresponding process in the case of the schizophrenic just because the former's psychopathology concerns recently acquired functions. Studying delusions and hallucinations constitute less stimulus to imitation than the therapeutic contacts with delinquents. These patients require us to identify by empathy with their open aggress-

¹¹ Such results may be caused by the inadequate handling of the delinquent's feelings of guilt. It concerns a part of the technique which I have not discussed here.

sions, their stealing, lying and embezzlements. In order to understand the delinquent, one must temporarily relinquish one's own moral standards and, since these are a recent acquisition the treatment of the delinquent becomes a greater danger than that of the schizophrenic. This may be one of the reasons why the treatment of so many delinquents is doomed to failure by the therapist's own resistance. This difficulty in understanding these cases of minor impairment through empathy reminds me of a general biological principle described by Goldstein. He found in brain injured patients that they adjusted more easily to defects completely blocking a vitally essential activity than to lesser disturbances (7, p 77).

In a comparable way it seems to be easier for the therapist to integrate the more serious disorder of schizophrenia than that of the delinquent whose vital psychological functions are injured to a lesser degree.

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SPECIAL PROBLEMS OF EARLY FEMALE SEXUAL DEVELOPMENT

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The sexual development of women is complicated by the presence of two main zones of erotogenic pleasure—the clitoris and the vagina. The most generally accepted theory of development of sexuality in women as stated by Freud is substantially as follows: the two sexes develop in much the same way until the onset of the phallic phase. At this time the girl behaves like a little boy in discovering the pleasurable sensations from her clitoris and associates its excitation with ideas of intercourse. At this stage the clitoris is the center of the girl's masturbatory activity, the vagina remaining undiscovered to both sexes. It would thus seem that the children of both sexes are at this point little boys—the girl being the littler boy considered from the angle of body sensations. With the change to a feminine orientation under the influence of the penis envy, the girl repudiates her mother and renounces clitoris masturbation, becomes more passive and turns to the father with the oedipal wish for a child, a state which may persist well into adult life or be only partially dissipated. Freud believed that the failure to make this feminine identification and the development of the masculinity complex in its place was largely due to constitutional factors: the possession of a greater degree of activity such as is usually characteristic of the male. He believed further that there was strictly speaking no feminine libido in so far as the female function was essentially passive from a teleological point of view and that Nature's aims (of reproduction) being possibly achieved through the aggressiveness of the male with little or no co-operation from the female, the masculine function is from a teleological angle more important and the female function correspondingly less differentiated.⁽³⁾ In his chapter on the psychology of women in the *New Introductory Lectures on Psychoanalysis* (1933) from which I have summarily quoted, he left the mechanism by which transferral of erotic sensation to the vagina was accomplished pretty much undiscussed. That it might be anticipated by the wish for a child from the father with a clearer idea of the child from within and a clearer conception of intercourse seemed possible—only to be accom-

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plished in many instances, if at all, by the actual experiences of intercourse is implied rather than expressed. That such a course of development occurs with relative frequency and that often no transferral of sensation to the vagina is accomplished is also the experience of all those who deal with the intimate problems of women. Freud considered that what he said about the psychology of women was incomplete and fragmentary. This paper is based on the closing admonition of his chapter: "If you want to know more about femininity, you must interrogate your own experience, or turn to the poets, or else wait until Science can give you more profound and more coherent information." From all three sources, I would proceed.

The material of this paper is drawn predominantly from cases of pathological sexual development and is such as may be open to criticism as the basis of deductions regarding normal female sexual development. Only in a few instances has it been possible to supplement it by observations on girl babies and children, and from the experiments and observations of other investigators. It is necessary at the very outset to establish these limitations, and present the material as problems of female sexual development rather than attempting any consistent theory. It seems, however, that pathological conditions often are the source of much stimulation for deductions and observations regarding normal conditions, and it is hoped that this presentation of problems may serve ultimately therefore to extend our knowledge of the normal as well as of the disturbed sexuality of women.

As has been repeatedly indicated in previous papers, it is my belief that genital stimulation may occur much earlier than the phallic stage, and that it occurs in situations of extreme or general stress to the organism where there is a diffuse surcharging of the neuromuscular equipment and a consequent utilization of all mechanisms of discharge. That such discharge tends to be mediated first through the organs whose functions have already matured is evident, but under conditions where relief in this way is insufficient it appears that there may be a diffusing into systems not yet quite matured, and a premature functioning which might conceivably then promote their anatomical and physiological maturing in the way indicated by Langworthy(13) in his investigations. If the strain is not too great. That such a forced premature functioning may occur and become established at a moderately stable but vulnerable level is quite apparent in the common experience of bowel and urinary training which is accomplished before the neuromuscular development has reached its optimum state.

In the investigation of the development of female sexuality the relation between two main erogenous zones, the clitoris and the vagina,

must always be considered. It may be, however, that the progressive development does not always follow so regularly the sequence outlined already as we have thought. In this same chapter on the psychology of women (p. 161) Freud states, "It is true, that here and there, reports have been made that tell us of early vaginal sensations as well; but it cannot be easy to discriminate between these and anal sensations or from sensations of the vaginal vestibule; in any case, they cannot play a very important role." It is only with this last conclusion in regard to the importance of the observations that this paper would wish to bring further evidence; i.e., in regard to the question of the significance of such early sensations—and as a part of this problem, their peculiar relationship in time and in meaning whether in contrast to or in amalgamation with clitoral sensations.

The material of this paper will be discussed under the following headings:

(A) Indications and conditions of early vaginal sensations; (B) Evidences and frequency of prephallic clitoral sensations; (C) Clitoral stimulation during the phallic phase; (D) Early situations in which a bipolarity between clitoris and vagina occurs; (E) Later results of bipolarity of clitoris and vagina; (F) Conditions of vaginal dominance; (1) through special accentuation of vaginal stimulation; (2) through bypassing of clitoral stimulation and (3) through repression of clitoral sensations; (G) A special elaboration of the penis envy and castration complex in which the struggle is reflected on to the breast-testicles—"the Medea complex," and finally; (H) A review of the literature.

INDICATIONS AND CONDITIONS OF EARLY VAGINAL SENSATIONS

For many years I have had the impression, based wholly on clinical observations, that vaginal sensation does not develop by any means uniformly secondarily to that of the clitoris, and certainly does not always await actual intercourse for its establishment, but may be concurrent with or even precede clitoral sensation. In deeply regressed psychotic women patients it is noted that autoerotic sensations are of a vaginal type in an unusually high proportion of patients. This was obvious to me during my years in psychiatric hospitals in the direct observation of masturbatory practices as well as in the bizarre hypochondriacal complaints and delusions of such patients. Thus the genital orgasmic explosions complained of by some schizophrenics as annoyingly produced by others seem more often located in the vagina than in the clitoris, even in women who have been vaginally frigid in their prepsychotic conscious sexual lives. The automatic orgasm of latent psychotic patients or those in a state of pro-

longed panic is more often vaginal than clitoral. Here the orgasm occurs spontaneously without manipulation or conscious fantasy, and literally overtakes and bewilders the patient who is sometimes unaware of what stimulus in the environment has set off the discharge. According to what ever clinical investigations I have been able to make, this particular type of vaginal orgasm seems to occur in patients who have suffered long severe and early anxiety and who show other autoerotic discharges as well. I have thought that it occurred then as part of the revival of an intense polymorphous perverse period in which the incapacity of the weak infant to endure the overstimulation to which it was subjected caused a diffuse and disorganized general response with discharges through many channels, including the genitals even before genitalization had become a well focused phase, as already mentioned.

Fitting in with this is the fact that such spontaneous vaginal orgasms rarely give adequate relief and are felt by the patient as being shallow, and not so sharp as the clitoral orgasm nor so full as the more regularly aroused vaginal response.

It has appeared, however, that there are also vaginal sensations derived from early rectal and anal stimulation—a fact clearly recognized by Freud, in the quotation already cited. It is to be remembered that in the girl the lower rectum and the vagina have actually been fused into a common opening, the cloaca, until relatively late in fetal life, and even at birth it may be that this differentiation is incomplete in the central nervous system localizations—in other words that the fetal central registration, or body image weak as it probably is, may still persist. The fact that in many infants a stimulation of the mouth through feeding produces a readily observed lower bowel stimulation (which may in the girl communicate itself to the vagina as well) gives us an additional understandable factor in the mouth-vagina equation universally present in women. That this is not on an intellectual visually symbolic basis was amply evident to me in the analysis of several women patients. One patient, at a time when she suffered from a severe paroxysmal cough, awoke in a coughing fit to find herself in a simultaneous vaginal orgasm associated with a dream which showed quite clearly the mouth with entrance to lungs and oesophagus equated with the genital groove with anal and vaginal openings. I have also recovered evidences of similar states in childhood in patients who had then suffered from severe whooping cough.

In some instances there is a special linking of the activity of the musculature of the vaginal introitus with anal sphincter activity and with the acts of suckling and swallowing. This seemed possibly the situation in the case of the patient with the audible vaginal tic, mentioned in my second paper on the 'Predisposition to Anxiety' (6). It may not be a mere

figure of speech to refer to this condition as a kind of smacking of the vaginal lips associated with air swallowing. In cases where there has been much oral stimulation in infancy associated with strong anal sphincter arousal, or where this latter has been accentuated by early constipation and the use of enemas and suppositories, the vaginal introitus itself may become involved in the anal sphincter sensitization and vaginal sensations from this area become well marked and strong. Such rhythmic vaginal contractions, clearly felt as comparable to swallowing, are described occasionally by women patients and may be observed directly in the course of gynecological examinations. They are associated with subjectively felt erotic sensations in varying degrees, sometimes being quite detached. This specially strong sphincter responsiveness favors the development of vaginismus, which further promotes and is in turn determined by the development of severe castrating desires as part of the penis envy problem.

Just as oral stimulation may produce lower bowel (and vaginal) activity in the infant, so oral frustration may produce a special form of active response, evident in the erection of the male infant—in Halverson's experiments (7)—but not readily visible in the female infant. This may produce sufficient stimulation to set up a masturbation by thigh pressure and/or a vaginal discharge. It should be noted, however, that such a local response, even if not apparent grossly, would promote genital (and if I am correct, generally vaginal) sensation which would be registered somewhat in the central body image of the infant. Here again I must differ slightly from Freud's idea that children of both sexes know nothing of the vagina early. I am impressed in the course of analyses that in some female patients there has been some kind of vaginal awareness very early, hazy and unverified though it is. This may occur quite definitely even in patients who have not had extreme early stress. This has also been noted by a number of other analysts whose observations will be discussed later in this paper. Vaginal awareness is further increased in those female patients who in infancy have been subjected to repeated stimuli of the rectum and anus, and when this stimulation has occurred before the phallic phase, a strong oral vaginal response occurs in reaction to primal scene observations.

EVIDENCES AND FREQUENCY OF PREPHALLIC CLITORAL SENSATIONS

Clitoral sensations do occur in some children earlier than their regular appearance with the phallic phase, but, in my experience with analytic patients, are much less frequent than vaginal sensations. At first thought this might seem peculiar inasmuch as erections in the male infant occur quite frequently and are especially noted under conditions of

stress Further consideration and comparison of the anatomical relations in the two sexes presents a reasonable basis for the clinical observations In the female the greater connection between the vagina and the rectum may mean that the vagina is readily stimulated by anal discharges and, since this mechanism matures earlier than that of the clitoris, the vagina thus regularly borrows stimulation earlier, and the clitoris would only receive such stimulus as could not be discharged at the earlier level In the girl child, bladder distension seems to merge in sensation and stimulus with the rectum and vagina while irritability of the urethra may sometimes combine with clitoral sensations but more often with sensations from the vaginal introitus The urethra is actually closer to the vaginal opening than to the clitoris Examination of a sagittal section of the pelvis shows quite clearly how distension of the excretory organs bladder or bowel, would produce mechanical pressure stimulation on the vagina more readily than on the clitoris, which is rather surprisingly isolated from the other organs In the male, on the other hand, urinary functioning causes a direct stimulation to the penis, and since there is only the one organ of genital pleasure discharge, this alone can be available also for channeling diffusion responses from central stimulation

In those patients in whom clear clitoral sensations seemed to have occurred in the prephallic phase, I have suspected and in some instances had definite evidence that there had been direct manipulation of the clitoris by the mother or nurse in repeated overanxious cleansing activities, in the effort to break up adhesions around the clitoris—one form of the so-called female circumcision which used to be advised by doctors as a cure for or a prophylactic against masturbation, which it actually promoted Since the clitoris is extremely variable in size and in degree of exposure—although commonly it is fairly effectively embedded—these facts alone must influence the amount of casual stimulation to which it is subjected, and the latter vary accordingly much more than in the analogous stimulation of the penis

CLITORAL STIMULATION IN THE PHALLIC PHASE

That the maturation of the clitoral sensitivity to stimulation in the phallic phase causes it to be the site of spontaneous masturbation in the girl is probably the usual but by no means the universal story, in this way differing somewhat from the boy where the constant inevitable stimulation of the penis by bedding and clothing and the permissiveness to handle the organ in urination cause a uniformity of response to the heightened sensitivity initiated by the phallic phase In the girl however, the masturbatory clitoral stimulation undoubtedly becomes fixated when

the little girl at this particular time and under the influence of awareness of the pleasure of her organ, sees a contemporary boy either urinate or masturbate. The very focused quality of pleasure to the girl then becomes the occasion for intense jealousy of the boy and envy of his organ. This susceptibility to penis envy remains heightened, I believe, until and throughout the oedipal period because of the inevitable frustration in the wish for the child and the relatively recent phallic discovering in her self. Under the influence of the disappointment about this, the regression to the wish to have a larger pleasure organ is obviously easy and increases the masculinity complex. All this may be very much heightened if a younger brother is born at this time, in which case the girl's masculinity takes the form of a particularly heightened masculine maternity or of a frank identification with the masculine sex through the adoption of the illusory penis—the assumption that she has a penis which is not directly visible.

Thus the castration guilt so typical of the girl may be quite short lived, and very quickly surmounted by the establishment of the illusory penis on the very basis of the clitoral awareness and the peculiar reinforcement of the penis envy under these special circumstances.

EARLY SITUATIONS IN WHICH BIPOLARITY BETWEEN CLITORIS AND VAGINA DEVELOP

Some degree of bisexual identification probably occurs in most girls at some times during the latency period, unless the girl remains almost exclusively under the domination of prolonged oedipal striving. However strong the masculine identification may be in conscious or unconscious fantasy, still there is a reality knowledge supported by body image from reality sensations which does not permit the girl to abandon completely her feminine identification (except in those rare and extreme states of psychotic development where fantasy takes over). Quite occasionally in the course of analyzing women however, symptoms may be encountered which have arisen from an unusual balancing of the masculine and feminine identifications with a continued localization of genital sensations in the clitoris and in the vagina, the two never being harmonized—resulting in a confusion which has affected the sense of reality, especially the sense of identity, and interfered with the thinking. This clearly may contribute to states of depersonalization. Such a marked degree of polarization of feeling between clitoris and vagina occurs in my experience, when there has been (a) very early vaginal stimulation in any of the ways already mentioned followed by (b) a strong phallic phase, reinforced by observation of masturbation in a contemporaneous boy,

this combination of affairs resulting in an especially strong penis envy and establishment of very intense fantasy of having a penis. It is noted from clinical study that situations of early anxiety which have contributed to the overflow of stimulation to produce an increase in vaginal reactivity, produce also an incomplete development of the sense of reality, with a prolongation of the tendency to primitive identification with others in the environment (in other words, an incomplete separation of the self from the environment) and an increase in the tendency to magic thinking and fantasy. These very concomitants of the predisposition to anxiety would tend, therefore, to strengthen the intensity of the illusory penis with its primary locus on the clitoris if exposure to comparison with a boy has occurred during the stage of clitoral masturbation, to circumvent castration guilt. The displacement of the illusory penis to the inside certainly occurs in many girl children, utilizing the vaginal and upper rectal sensations. But under other conditions, especially if reality exposure to penis rivalry continues and clitoral masturbation is prolonged and is followed in the oedipal period by an especially poor resolution of the oedipal conflict with resultant identification with the father, the clitoral illusory penis persists with great intensity. It is also noted that if a strong oral anal vaginal stimulation has occurred before the phallic phase, the girl under the influence of the oedipal disappointment regresses not only to the clitoral pleasure, but in just those cases of the birth of younger brother at this time there is not only the increase of penis envy, but a further regressive tendency increased by the breast and oral envy from the sight of the baby nursing. Under these conditions an extreme polarity of oral vaginal and phallic clitoral sensitivity may develop. Looked at from another angle, it might be said that both pressures are so great that there is a real conflict between the body image based on the actual experiences and the fantasy phallic image which has its nucleus of reality in the clitoral sensations.

LATER SEQUELAE OF BIPOLARITY BETWEEN VAGINA AND CLITORIS

When both vagina and clitoris excitability have been established in an early, strong and mutually antagonistic way, the clitoris may be the site of a persistent and practically hallucinatory penis, and this is maintained generally throughout the latency period, i.e., the masculinity complex is particularly strong and this element plays a part in the overwhelmingly severe reaction to puberty. Such girls are frequently unusually aggressive during the latency period and may participate actively in all sorts of investigations, sexual and otherwise, but at the same time carry

on secret fantasies of great elaborateness concerning passive and masochistic activities. The condition of phallic hallucination involves not only a visual hallucinatory state but a combination of this with hallucinated tactile and tumescent sensations, derived not only from clitoral tumescence but especially from the overplastic body responses and 'body suggestibility' of children whose first stage of ego development in infancy has been impaired. It does not preclude the girl hanging on to the father with an oral vaginal babyish grasp which alternates with her phallic strivings. There is then actual conflict between the hallucinated phallic genital image and the actual body image arising from the endogenous vaginal sensations which may not be as sharp but have a longer history and the greater force of reality than the phallic ones.

This conflict between the two images of the genital self sometimes results in constant pendulum shifts from clitoral to vaginal orientation or may give rise to a state of unreality with the abandonment of the problem and a flight into thought of a characteristically vague and airy kind. This is most frequently seen in a well developed form under the influence of further anxiety generated by the onset of puberty, especially the appearance of the menses. Such girls may then frankly 'founder on the rock of puberty' and break down, or retreat into unproductive intellectuality and philosophizing.

Sometimes, however, one zone is disowned or suppressed in favor of the other. Probably the clitoris wins out more often, partly by virtue of its special capacity for sharpness of sensation, the repression of vaginal awareness being furthered by the female castration problems at puberty, which have previously been repressed or successfully defended against in the infantile period, especially when associated with actual experiences causing a fear of pregnancy and childbirth. A strong (latent) homosexuality develops with particularly stubborn vaginal frigidity. These patients may present superficially the appearance of the beginning of a sexual development resembling the ordinary sequence described by Freud but transferral of sensation to the vagina does not occur under the influence of real experience with intercourse.

CONDITIONS OF VAGINAL DOMINANCE

The condition in which the vagina, whether in its upper segment or in its introitus, appears as the leading or practically the only source of genital pleasure to the girl comes about (1) through an accentuation of vaginal awareness not balanced by the development of a strong illusory penis, (2) through situations causing either a bypassing of interest in the clitoris or the repression of clitoral interest and pleasures after its development.

The general conditions promoting premature awareness of the vagina, viz., conditions early in life, in the prephallic eras which cause an over stimulation of the infant and the need for total discharge reactions have already been discussed. Such conditions, especially when combined with prolonged oral stimulation with or without states of urinary or bowel retention but without marked anal sphincter stimulus—and especially in those infants in which there is not any definite synchronization of the responses in the entire gastrointestinal tract(5)—may promote a strong vaginal stimulation in the prephallic period. Stated in another way the receptive-distensive elements of the early disturbance are increased but in the absence of strong anal sadism. This is presumably due not only to the special vicissitudes of the infantile life but to differences in body constitution involving proportionately different peripheral muscle and visceral reactivities. If, on this basis penis envy is especially delayed due to the girl child being totally surrounded by females as occasionally happens when all the siblings are girls, or for other reasons girls are in the dominant role in the environment, then the vagina may take over and remain the leading erotic zone. The late competition with boys which follows lacks the keen personal rivalry so apparent in girls who have had an earlier penis envy with strong castrative desires or with definite illusory penis formation. No true masculinity complex seems to develop and the competition is either genuinely lacking or takes the form of a withdrawal from boys activities and a singular disregard of them. Such girls may be somewhat competitive with other girls, but even there the competition is not characterized by the sharp pressure which so regularly occurs among girls, in whom it is derived essentially from an earlier penis envy. It is my belief, based, however, on a very limited experience with this type of woman that other functions may become patterned after this essential genital one and that such women may appear vague, lack force in social and intellectual pursuits, but are not necessarily unproductive. In the one case that I worked with most thoroughly, there was a kind of withdrawn-ness which was not primarily a reactive introversion but which gave a superficial impression of a princess complex, though without haughtiness.

In this case there had been a practical ignoring of the clitoris probably due in part to its being small and deeply embedded as well as to other conditions which did not induce its being especially favored as it was discovered by the child under humiliating circumstances when she was not yet at the phallic stage. Clitoral interest was then inhibited and this became chronic—promoted by the actual anatomical smallness and protection of the organ. It should be noted however that clitoral sensation was not repressed i.e. there was no clitoral frigidity only its participation in erotic pleasure was never demanded.

It is conceivable that there may be a real failure of development of clitoral sensation due to a bypassing of the organ and a failure of stimulation. Such a case has, however, never come under my observation and it seems more probable that there is regularly some degree of clitoral sensitivity which develops by the spontaneous maturation of the phallic phase, and that this subsequently meets with repression. In those patients who presented a history of no clitoral sensations, deeper psychoanalytic investigation generally revealed that there had actually been a very intense clitoral phallic phase, which had occurred simultaneously with exposure to penis envy together with open threats from parents or nurses who observed the girl's clitoral masturbation. The latter may be so completely repressed that the clitoris remains frigid thereafter and is eliminated as the site of phallic strivings, the girl then either develops an especially severe castration complex with resultant masochism, or reallocates the phallic desire to other parts of the body, determined by special narcissistic and/or erotized foci, of which the vagina may be one. In such cases vaginal dominance takes over, the penis envy struggle sometimes resulting in a complete frigidity.

THE MEDEA COMPLEX²

There is a form of deformation in the sexual development of some women in which there may be an exaggerated semblance of femininity coupled with great narcissism and a desire for extreme revenge when the woman loses her mate through death, or especially if she suffers rejection at his hands. The analytic experience I have had with this type of woman leads me to believe that there is a rather special constellation of breast and penis envy with the severest form of castration complex, reflected in a breast-testicle comparison which allows the girl a specious expectation of superiority after puberty.

The basic situation which seems to favor this is the birth of a younger

2 According to the Greek myth Medea was a resourceful woman who helped Jason to seize the golden fleece by giving the dragon knock-out drops. She had fallen in love with Jason and quickly eloped with him, delaying her father in his pursuit by slaying her younger brother and depositing his bones where the father would find them and be distracted by his grief. Returning thus with Jason to the court of Pelias, his usurping uncle, she bore Jason two sons and succeeded in poisoning Pelias. Jason, still unable to seize power for himself, fled with his wife and two sons to Corinth. The tragedy of Euripides begins with the period in Corinth. Jason, the weak and boastful husband, resented his guilty indebtedness to his wife. He decided to marry the Corinthian princess, excusing this on the basis that this marriage would consolidate his position at Corinth and he could then pass on the protection to Medea and the children. Medea's possessive and single minded love for Jason turned to hate and revenge. She poisoned the Corinthian king and princess with poisoned gifts, and completed her revenge on Jason by killing the two sons who were dear to him.

sibling before the fifteenth to sixteenth month, that is in the preverbal era. The envy and jealousy of the baby, especially the baby at the breast, is felt by the little girl with an extreme oral intensity, and possibly can be compared to the terrible jealousy evident in some animal pets when a baby is born. If the baby is a boy or if a boy sibling is born within the next two to three years this original oral and visual envy is augmented by or converted into penis envy at the third to fifth year. The castration complex is extremely severe and the child may retreat to an oral craving for the mother or have especially pronounced oral components in the attitude toward the father. The primitive sense of deprivation and of being an outcast is very tenacious and forms a more than ordinary basis for the typical feminine guilt feelings of the developing castration complex. The image of the breast seems especially strong back of that of the penis and the compensation. I will have better and bigger ones when I grow up may finally be achieved in the postoedipal period of superego building.

Such children often clearly eliminate or disregard the penis and fixate rather on the testicles while the breast is exalted over any male genitals. They delay any adequate solution of the oedipal disappointment or the penis envy problem until puberty. Until then they feel deprived but hopeful. One patient of this type told me of an early memory from the fifth to sixth year period when the chauffeur's son had shown her his testicles. When I asked what had happened to his penis she at first said that she simply could not remember his having had one and then quickly brought another memory of another boy, also considered inferior but socially of her class who in school stood in front of the blackboard beside her holding his penis in his hand because he was probably ashamed of it. What a neat way of dealing with her envy of the boy's masturbation!

The oral visual incorporative drives toward the male genitals are especially strong where several younger siblings are born in the patient's early childhood—sometimes with a phase of hope of growing male genitals in this way, the hope being apparently abandoned but actually sustained in the reinstated idea of the breast as already mentioned. A considerable intensity of various drives may permeate the latency period but become consolidated at or just before puberty in the expectation of breast development under impact again with the castration complex and the onset of menstruation.

Such women are extremely fastidious in their dress and body form. This is a somewhat specious femininity, however both male and female genitals being represented in the breast. These young women often have an appearance of maturity and may be very beautiful but do not ever achieve a healthy integration and individuation. They are narcissistically lost without a man even for a brief time but they often marry childlike

or weak men Their attitude toward their children conspicuously lacks tenderness They may be very proud of them, are generally conscientious toward the children but not infrequently show a hostile type of anxious worrying If the marriage is disrupted the attitude toward the children may be uncovered in all its rawness, from spiteful possessiveness to revengeful abandonment The increase in tenderness and appreciation of the individuality of the child is lacking In the sexual response such women show sometimes a vaginal response (probably based on the extreme orality, with or without clitoral participation) It is possible they may be frigid, depending on other vicissitudes of development.

REVIEW OF THE LITERATURE

One is impressed with the general awareness of complexity of the subject of female sexuality in the minds of most writers, and with the relatively few theories advanced together with the large number of clinical reports indicating variations from or exceptions to the recognized theories I have, in my present paper, added to this impression of complexity and variability in sexual development in women I do not feel sure by any means, of the frequency of the occurrence of the different types of feminine sexual organization which I have presented in this paper in the development of the more ordinary neuroses of women, having to recognize that my own practice has included a rather disproportionately large number of cases of severe neuroses and latent psychoses and that my earlier psychiatric experience of nearly fifteen years was predominantly with psychotic patients

I shall make no attempt to make a systematic review of *all* of the literature or to present the historical development of different points of view regarding female sexual development but attempt to stress rather that which has special pertinence to the points which I have raised in this paper viz. (a) the possible early vague awareness of the vagina which however is not subjectively adequately differentiated from the rectum (b) the influence on vaginal awareness and reactivity by states of oral stimulation or frustration (which may be registered at the lower end of the gastrointestinal tract as well) by direct stimulation of the rectum and anus and by a surcharging of the organism by massive stimulations greater than can be cared for through appropriate channels of discharge, so that immature discharge mechanisms may be prematurely stimulated. As a corollary to this there is the implication that there may be distortions of the regular sequence of preoedipal development, or in the extreme different types of preoedipal organization This leads to (c) the consideration that clitoris and vagina may have varying relationships to each other, with a patterning which has a far reaching influence on the sexual re-

sponse of the woman and a deep sometimes decisive effect on her character and even sometimes on her intellectual functioning

I am inclined to question whether these differences in organization may not be the bases of some of the opposing points of view expressed by theorists where the observations of some one type of organization may have been quite impressive and diverting and yet not really worthy of a complete controversion of the basic theory

Freud's basic theory regarding female sexual development as stated in his *New Introductory Lectures* (1932) has been summarized at the beginning of this paper. In his paper the previous year (4) he gave a somewhat more explicit account and raised more clear cut questions on which my own presentation has bearing. In this paper he was greatly concerned with the preoedipal developments in the girl emphasizing that the early attachment to the mother both in intensity and form lent much to the subsequent oedipal attachment to the father, that this attachment to the mother did not terminate as early or as decisively as had been thought, but continued on into the phallic phase when it might be found as part of the girl's phallic strivings toward the mother—and that in some cases was never relinquished, the woman treating her husband as she had previously felt toward her mother (rather than her father). While he commented here as in other papers on the number of investigators who believed little girls did have early vaginal sensations yet he seemed rather to dismiss this again and stated categorically that we may justly assume that for many years the vagina is virtually non-existent and possibly remains without sensation until puberty. Again in the same paper, however, he commented on his own difficulty in exploring adequately the early development of female patients because (with him) such patients have been able to cling on to that father attachment in which they took refuge from the early phase and he believed that women analysts were better able to apprehend the facts with greater ease and clearness because they had the advantage of being suitable mother substitutes in the transference-situation with patients whom they were studying. In a paragraph in which he discussed the girl's phallic wishes toward the mother and the way in which children react with passionate rage toward the giving of an enema by the mother and then reverse the proceeding with the wish to attack her he stated that he had understood their peculiarly passionate fury when Dr. Ruth Brunswick had interpreted this as comparable to the orgasm following genital excitation and that the accompanying anxiety should be construed as a transformation of the desire for aggression stirred up and that on the anal sadistic level the intense passive excitation of the intestinal zone evokes an outbreak of desire for aggression manifesting itself either directly in the form of rage or as a consequence of suppression as anxiety.

It has seemed to me, although I am by no means completely sure of the situation, that in these severe enema situations of early childhood the reaction is even more complex, dependent on the amount of actual pain involved and on the attitude of the mother, and that the fury represents indeed a phallic attack sometimes associated with clitoris stimulation, but consists much more in the excitement which cannot attain full orgasm—it leaves the child exhausted rather than relaxed. One encounters this, I believe, even more intensely in boys than in girls. In girls, as I have previously indicated, it seems that the clitoral stimulation is associated most with the extreme sphincter stimulation, whereas the rectal stimulation itself may cause a reaction in the vagina which reaches an orgasmic like climax and relief with the discharge of the bowel contents. In such situations both vagina and clitoris may be stimulated and do not act in harmony. Certainly the situation is by no means entirely simple or clear, and deserves further study.

It is noteworthy that a number of analysts, Lampel de Groot(12), Jacobson(9), Sachs(16), Muller Braunschweig(14), Payne(15), Brierley(1) have all noted the primary appearance of vaginal sensations but this has been studied largely as part of a situation involving castration anxiety and beginning superego formation, earlier in the girl than in the boy. Freud's own comment concerning Melanie Klein's(11) displacement backwards of the oedipus complex to the beginning of the second year, and Fenichel's objection to it, is an extraordinarily valuable one. Although stating that Klein's deductions are not compatible with his own reconstructive findings in analysis and especially with his observations regarding the long duration of the girl's preoedipal attachment to the mother, still the apparent incompatibility might be softened by the realization that what is demanded rigidly by biological laws and what is subject to shifting under the influence of accidental experience is by no means easily distinguishable. It is exactly in the varying developmental speeds and combinations which may be promoted by accidental or forced premature functioning and/or by the linking of different body systems in stimulus and discharge situations that I believe there may be varying preoedipal configurations established, of particular import to the girl because of the two zones of genital reactivity.

The observations of Ernest Jones, expressed in his *Early Development of Female Sexuality* (10) have considerable significance in regard to the content of my present paper.³ At this early time (1927) Jones had

3 Jones remark "There is a healthy suspicion growing that men analysts have been led to adopt an unduly phallo-centric view of the problems in question the importance of the female organs being correspondingly underestimated. Women have on their side contributed to the general mystification by their secretive attitude towards their own genitals and by displaying a hardly disguised preference for interest in the male organ" reminds us that anatomical structure promotes these attitudes the man's organs are central and visible whereas the woman's are mysteriously secreted.

already noted that in women with an extreme attachment to the father this had generally been preceded by an equally extreme fixation in regard to the mother, definitely connected with the oral stage. He indicated further that following the oral stage there tends to be a bifurcation into clitoris and fellatio directions—'with digital plucking at the clitoris and fellatio phantasies respectively the proportion between the two naturally differing in different cases and this may be expected to have fateful consequences for the later development.' He believed that in the normal heterosexual development the sadistic phase set in late, neither oral nor clitoral stage receiving any strong sadistic cathexis, and that therefore the clitoris did not become associated with a particularly active masculine attitude, nor on the other hand was the oral sadistic fantasy of biting the penis at all highly developed, that rather in the normal heterosexual development, the oral attitude is largely a receptive sucking one and passes into the anal stage. The two alimentary orifices thus constitute the receptive female organ. According to Jones, *The anus is evidently identified with the vagina to begin with, and the differentiation of the two is an extremely obscure process, more so perhaps than any other in female development.* I surmise, however, that it takes place in part at an earlier age than is generally supposed — This mouth anus vagina represents an identification with the mother."

Although I have found evidence of the degree of oral sadism described by Klein and Jones, occurring only in adults and exceptionally impaired infancy (mostly in latent psychotic individuals), the emphasis on the early oral anal vaginal anticipates very much the findings which I have described and believe to be relatively frequent. Ruth Brunswick in her paper on the preoedipal phase of libido development(2) called definite attention to vaginal sensitivity arising early, associated with anal stimulation but considered it probably minor. Hendrick(8) reported a direct observation in which a three year old girl was obviously aware of pleasurable sensation from both clitoris and vagina, and in which the behavior suggested an association of vagina with anus yet a definite differentiation from it. It is possible that a careful scanning of the experience of pediatricians would bring much more evidence of this kind to light.

CONCLUSION

The importance of the present paper, incomplete and sketchy as it is, may lie in its indicating not only the probability of varying configurations in the bi zonal female sexual development in the preoedipal phases rather than merely by the different degrees and routes of the resolution of the castration and the oedipal complexes, but especially in the further indications of the existence of different types of interorganization of the preoedipal phases in general, whether male or female.

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DEVELOPMENT OF THE WISH FOR A CHILD IN BOYS

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It is woman's biological destiny to bear and deliver to nurse and to rear children. However great the father's share in the care of his offspring it is the mother-child unit which develops the first germs of human love and functioning in the child.

No wonder that biological instincts, experience and education combine already in childhood to prepare the woman for her future role as a mother. In fact the wish for a child plays a predominant part in the psychosexual development of the little girl. Promoted and influenced by her castration conflict it may have normal vicissitudes, may be inhibited or warped but eventually will shape up to specifically patterned attitudes which find individual expression in more or less mature or infantile loving or ambivalent relationships to her children.

Since this problem is of such paramount significance in a woman's life the analytic productions of female patients inevitably force attention on it. Hence we have studied the normal and pathological vicissitudes of the female wish for a child from all possible perspectives. But what about the corresponding problems in man? Although Freud (1, 2) long ago described pregnancy fantasies and the wish for a baby in boys or men respectively there are no psychoanalytic papers dealing explicitly with such problems in men except for a paragraph in Brunswick's article on the Pre-oedipal Phase of the Libido Development (6). Yet men too must be psychologically prepared for their role as a father. Certainly the wish for a child in men must also have an infantile history which deserves interest. There are few male cases indeed whose analysis could not contribute pertinent genetic material although this issue is not in such a central position as in women. Why such studies have been so conspicuously neglected is a question which I shall venture to answer below.

Occasionally we even meet male patients whose frustrated wish for children has been essential in the causation of their neurosis. In two such cases the patients—both obsessional-compulsive types with paranoid mechanisms—came for treatment with the same complaints that their marital relationship had been seriously affected by the sterility of their wives. They felt unable to accept childlessness; they brooded about their

misfortune, were resentful, and depressed. They played with fantasies of divorce and remarriage with a fertile woman but could not desert their wives because of their severe feelings of guilt.

The analysis of their unconscious conflicts brought into focus the intermediary developmental stages of the wish for a child in little boys. One of the patients actually did get a child during his analysis and developed strikingly neurotic paternal attitudes and symptoms relating to the baby. This is the reason why I want to present his case below. First, however, I shall try to draw a general genetic picture of the development of the wish for a child in little boys. Unfortunately, much of what I have to say will be but a repetition or re-emphasis of well known facts.

I

Ruth Mack Brunswick(6) pointed out that in girls and boys both, wishful thinking about a baby arises very early during the preoedipal stage of development.

It makes sense that we provide babies in even the first year of life with little rubber dolls and animals. When left alone, the child turns his attention to these toys, investigates them and gets used to them as comforters. But it takes some time until in his second year of life, he begins to relate to and to play with his animals and dolls. Gradually, these activities become meaningful 'mother and-child plays' which reflect and reverse the baby's situation. He feeds and diapers the doll, praises and scolds it, in short, he takes active care of it and handles it the way he feels he is or wants to be treated by his mother. We know that this familiar type of play activity represents the baby's desire for active self-assertion and independence of the mother and for mastery of his preoedipal conflicts. The underlying fantasies are part of the unconscious material which has been highlighted by Melanie Klein(5). I described and discussed such fantasies years ago in a little girl analyzed at the age of three(3). They correspond to material encountered in the analysis of adult male and female patients with strong preoedipal fixations.

Frequently babies tell their mother frankly that they hope to grow up quickly and one day be mothers while their mother will then be a baby.¹

Such stories are expressions of ambivalent unconscious strivings to eat up the breasts or the whole body of the mother and to restore her again by reproducing her through anus—or mouth or navel—as a baby which they can actively dominate, love and punish, in the role of the

1 A little girl of three listening to a story about "Foxlox who eats up everything" told her mother "And the fox ate it up and you came out." And later coming from the toilet "I just made a Mommy!" And then "Let us play you are my child and I'm the Mommy. And I'm your child and you are the Mommy."

mother. These fantasies establish an equation of breast, womb (intestines, feces) and baby which is often kept alive in the unconscious of pregenitally fixated persons²

It must be stressed that fantasies of pregnancy and delivery by the oral incorporation and anal rebirth of the mother appear to precede the phallic stage in little girls and boys the wish for a baby is historically older than the wish for or pride in the penis. The wish for a child even seems to reflect, at first, only the mother child situation without involving fantasies about the relationship between the parents

But soon the father enters the scene as a rival and love object and the child develops fantasies about the parental relationship. The earliest set of pregnancy and birth fantasies is gradually transformed and related to primal scene concepts. The child imagines that father impregnates mother by defecating or urinating into her or that mother grows children by drinking his urine, by eating his feces or part of his penis and so on. Such fantasies, *albeit* still on a pregenital level reflect the growing interest in the phallus and the distinction between the respectively active or passive roles of the male and the female in intercourse and reproduction

Consequently, in both girls and boys, active, phallic impulses arise to compete with father, to impregnate mother, and to get a baby from her in return. The earlier passive pregnancy wishes shift from mother to father, from her breast to his penis that is become in boys part of their homosexual fantasies and their feminine identifications with the mother. At this stage we find wishes relating to the father which are similar to those previously directed to the mother wishes to incorporate the father's penis or feces and to reproduce him as a baby boy with whom the father son relationship can be reversed. The original breast baby equation is changing into a penis baby equation which, in the little girl paves the road to the solution of her castration conflict

This leads to the beginning of the oedipal period. Up to this stage I do not believe that we find much difference in the wishful active and passive baby fantasies of little boys and girls. But the discovery of the difference of the sexes and the ensuing castration conflict from now on gives the sexual fantasies of girls and boys a new and different meaning and direction. In girls the realization of their femininity intensifies wishes for growing a baby which might substitute for the supposedly lost penis. In the little boy, the discovery of the female genital though mobilizing castration fear, normally affirms his phallic identification with the father

2 A depressive male patient grieving about his middle aged wife who was approaching loss of fertility called her womb an "empty vessel" which would never give him children again

Consequently, active masculine drives to impregnate the mother by sexual intercourse win out over homosexual feminine wishes. Comparing boy and girl, Mack Brunswick stated that the boy has to sacrifice his wish to grow babies, as the girl has to renounce her desire for a penis⁶.

The little boy's successful advance to oedipal fantasies about a child from his mother and his renunciation of feminine pregnancy and child wishes are a decisive step. In fact, they are a prerequisite for a normal development of man's desire for children and for his future attitude to his children.

Two major infantile experiences seem to be of greatest influence on the outcome: the castration threat and the birth of a younger child. As the case history to follow will show, severe castration fears may have an effect on little boys analogous to that of the castration conflict on little girls. In patients with latent homosexual problems we may encounter a certain type whose feminine trends appear to hinge mainly around an intense envy of woman's ability to grow and produce children. These men seem to be unable to renounce or to sublimate their wish to grow children themselves. Men of this type may be potent. Many of them are eager to marry but actually regard marriage only as a means of getting children. Their analysis shows that they have withdrawn cathexis from their penis, displaced it onto the wish for a baby and maintain most vivid illusionary expectations of growing children. They identify with their wives during pregnancy and childbirth and compete with them avidly in regard to the maternal care of the baby. They show neurotic—overaffectionate anxious narcissistic—attitudes toward their children and, as in the case of my two patients, are severely disturbed when they are faced with childlessness.

Among this group of men we frequently find creative persons, for example, artists. In case they come for treatment, the analysis of their creative activity regularly shows intensely cathected unconscious feminine reproductive fantasies. It appears that creative work quite normally is the main channel for sublimation of feminine reproductive wishes in men.

Among my male patients, I have had occasion to observe such an intense and persistent envy of female reproductive ability—an envy which is often disguised by a seemingly normal masculinity—only when a younger child had been born at the peak of their castration conflict.³

Their mother's pregnancy and the birth of a baby always confronts children with severe problems. The pregnancy stirs up primal scene fantasies and often revives pregenital concepts. When the infant is born the older child will feel deserted and will experience a severe rivalry conflict.

3 It almost seems that the arrival of another sibling is either tolerated better or else inhibits the little boy's masculinity more thoroughly when such an event occurs at an earlier age.

both with the father and the newcomer. In this situation the identification with the mother in her love and care for the baby lends itself as a good method of coping with all these problems. It helps the child to accept his inability and fear of competition with the father, it enables him to bear his own loss of maternal care, to overcome his hostility towards the newborn and his desire to replace the infant. In little girls, such maternal identifications represent the most desirable solution of their problems. But it seems that little boys, also, regularly develop such maternal trends, *albeit* normally only as temporary transitory defense reactions to the arrival of another child. When they persist, even under the cover of masculine attitudes, they indicate a deeper disturbance and represent not only defensive reactions to the traumatic event but a specific pathological solution of the castration conflict. Such was the case in the patient who will be discussed below.

Normally, we find only a longer or shorter period of great attention to the new born and to the mother's care of the infant, a period which frankly shows the struggle between the conflicting desires to be father or mother to the infant or to replace the baby. The maternal identifications of little boys during this phase are often quite obvious. But eventually, the child gets used to the intruder, feels secure in his new superior position and establishes a relationship to the infant which alloys paternal wishes with surviving maternal fantasies. Gratifications gained from his participation in the baby's care help to reduce his envy of the infant. But mostly we see that, after a period of great emotional concern with the infant, little boys will lose much of their interest in the newcomer. It seems that they can renounce or repress their envy of the infant mother relationship most successfully by withdrawing interest from both. Protective reaction formations help to strengthen their phallic masculine position. Such little boys often express contempt for the younger child—especially when it is a girl. They neglect the baby, and turn to common activities with other boys and with the father. They hate to have to play with and to take care of the younger child. These are attitudes which, in general, seem to be characteristic of most little boys as they approach latency, even if they have not had the experience of the birth of another sibling. While previously they loved to play with little animals such as Teddy bears or monkeys, they will certainly turn away from them at this time. Their behavior indicates that they have definitely given up pre-oedipal wishes of having a baby or of being a baby.

During latency, the difference in the attitude of boys and girls to the child problem becomes blatant. The little girl will play with dolls up to puberty in conscious anticipation of her future destiny. The normal little boy will usually show disgust at his little sister's activity and especially at

girls' silly games with dolls. But in a group of children he may consent to assuming the role of father in parent child plays.

At this point we may leave the little boy in his latency years and return to him when grown up and beginning his adult sexual activity. The difference in the behavior of boys and girls in late adolescence clearly shows the vestiges of their psychosexual childhood history. Whereas the girl of eighteen or nineteen is absorbed by the problems of maternity, the boy of the same age is far from having fantasies about children of his own. His major concern in this respect is how to have sex without impregnating his partner. Social factors are partly responsible for the different attitudes of adolescent boys and girls. But the absence of a longing for children in men until they approach marriage is also due to firm defenses against their envy of woman's reproductive functions. At this point I would like to express my suspicion as to why male analysts may have neglected studies on the male wish for a child. They may be blocked by these very reaction formations against unconscious feminine wishes to grow children. Of the forcefulness of these defenses I have had sufficient evidence from the analysis of male patients—including students—in particular those patients who pursue sexual activities for years without wanting marriage or children. After having married these men would delay and deny their wives' demands for having children. In the course of analysis, their conspicuous disinterest in having children of their own regularly proves to be a stubborn defense against a deeply repressed envy of woman's reproductive abilities.

Normally, when a man wants to settle down in marriage and have children, his longing for children expresses his love for the partner and his readiness to assume the responsibility of a father based on identifications with his own father. But these mature realistic trends are mostly fused with deeper irrational strivings. Marriage, the beginning of a new life and the end of a carefree, less responsible period of life, confronts both men and women with the limitations and shortness of their own lives. Though turning their minds to future happiness this significant event inevitably stirs up fears of death and enhances reactive wishes for omnipotence which they can gratify by having children in whom they will survive.⁴

Such narcissistic components in a man's longing for children are apt to revive again his infantile frustrated feminine reproductive wishes. Especially, when he has had experiences of his mother's pregnancy in childhood, they will lend themselves to his present fantasies. As his wife gets pregnant, oedipal and preoedipal experiences will be easily mobilized and

⁴ In a paper on female prisoners I mentioned their preoccupation with getting babies right after their discharge as reaction to the fear of harm and premature death aroused by their captivity (4).

give his attitudes a special coloring. Many men show a particular enthusiasm for their work during their wife's pregnancy, others develop neurotic behavior or symptoms which show their identification with the pregnant woman. In both husband and wife infantile unconscious equations of the expected baby with their mother and their father and with the sibling rivals may be revived and become the unconscious carrier of various narcissistic expectations or fears that the children might look like and have the personality traits of their parents or brothers or sisters, that they will achieve more than they did themselves, that they might embody their own high pitched ego ideals, etc. The infantile conflict may be enhanced in a man during his wife's pregnancy by his sexual frustrations caused by her condition, and later by the nursing of the infant.

Man approaches the birth of his children with all varieties of mature or infantile object libidinous, and also highly narcissistic fantasies and conflicts. It is the actual birth of the child which enables him, if he is normal, gradually to eliminate disturbing infantile and narcissistic elements and to transform his fantasies into healthy paternal love relationships to his children.

The success of this last decisive step from man's wish for a child to his object relationships with his children certainly depends to a large extent on his past history, mainly on his successful identification with his father and on the mastery of his rivalry conflict with his siblings. What either supports his advance to maturity or may provoke renewal of infantile conflicts is the attitude of his wife and also the personality of his child: its sex, its nature and its development. All these component factors will combine and result in specific and different patterns of behavior toward each individual child of his own.

II

In the second part of this paper I shall present clinical material on my patient Jack who came to analysis because of his neurotic reactions to his childlessness. His case is interesting because as I mentioned above, his wife did become pregnant in the course of his treatment and the development of his neurotic attitudes to the child could be observed at close range.

Jack is a young lawyer in the early thirties who from early childhood on had suffered from psychosomatic symptoms and mild hypochondriacal fears. What brought him into treatment however was his problem of childlessness. Jack had married a charming young divorcee with whom he had fallen passionately in love. What had attracted Jack to his wife had been a loveliness which as he realized later in his analysis had reminded him of his own past charm and beauty. Her reluctance to give up another male friend for him surprised and

stimulated him. He promised her heaven if she would marry him and was triumphant when she did. He started his marriage with the most idealistic intentions. But soon he began to be severely disappointed and resentful of his wife and his in-laws. He felt "cheated." He accused her of incompetence, laziness, selfishness and aggressiveness—in fact, of all the weaknesses with which he himself obviously struggled. He complained that she was overly attached to her unreliable father, a wealthy man who had refused to give them an adequate wedding gift or financial support. Jack felt that even his wife's beauty had "fooled" him because it disguised her ugly pendulous breasts. He treated his wife unkindly, nagged and criticized her constantly and complained bitterly about the aggressive reactions which he himself had provoked.

Such was the marital situation when a serious illness of his wife, an infection of her ovaries brought Jack's marriage to the verge of collapse. His wife had to have an operation. In the opinion of her physician pregnancy was impossible. This was a terrible blow to Jack who had always felt a tremendous longing for children. To make the situation worse, he had himself contracted an unspecific, harmless but painful genital infection from his wife which took years to cure. Their sexual and emotional relationship deteriorated. Jack lost his sexual desire for his wife and became more and more hostile. He developed resentful fantasies of another wife who would give him many children and of sexual affairs with large breasted women who would give him full sexual pleasure without demanding anything in return.

In this state Jack came to analysis. During the first period of his treatment I suggested that the couple consult a certain specialist in sterility problems whose treatment resulted in immediate pregnancy. Jack and his wife were very happy. However, during the last period of pregnancy, Jack began to develop increasing anxieties and expected a miscarriage any day. The child was born without complications—a healthy, pretty, little girl who looked like her father.

Jack was beside himself with joy and love for his daughter. He adored and worshipped her. He gave her all possible pet names but called her mostly by an Irish boy's name. He admitted that he was very proud that she was such a pretty girl yet looked and acted like a boy. Since she resembled him greatly, he was aware of his own identification with her. Soon he became very anxious and overprotective and worried continuously about the baby's health, her weight, her physical and mental care. He loathed visitors who might either infect her or overstimulate her and make her "neurotic." Although his wife was a devoted mother, Jack accused her of not nursing the child properly, of exposing the baby to dirt and every other kind of harm. He constantly interfered with his wife's maternal activities and tried to take over the care of the baby. When the child contracted some mild infection he became desperate. He talked of suicide in case anything should happen to his child. He began to suspect that the child had contracted a TB infection first from one, then from another nurse who actually had had glandular TB. Jack had the child tested repeatedly and constantly observed her temperature, her stools and her behavior.

All these symptoms and his preposterous acting out developed under my eyes. Jack's obstinate mechanisms of denial, projection and isolation made him

at that time inaccessible to analysis. But during the last year he has gradually gained sufficient insight and the results of his analysis are shown in a subsiding of his symptoms.

The key to the neurotic problem of this patient is his peculiar oedipal history. From his birth on Jack had achieved a blatant but spurious success: his mother had worshiped him in the same manner as he now adored his child. She had always loved the charming and handsome boy more than her other children and even admittedly more than her husband who was a good natured but over critical and irritable man given to constant temper outbursts. But Jack had understood how to handle his father too and to gain even his special favors. He was scared only of his two year older brother Edward who showed his jealousy conflict by being alternately overaggressive and overprotective toward the younger boy. The relationship between the two brothers was a real Jacob and Esau story. Jack the fair smart younger boy had stolen the right of the first born from his homely rough and tough but decent brother. Spoiled and preferred by both parents Jack consequently went to better schools and made a much better career than Edward who was the more talented and reliable of the two. In accordance with his mother's wishes it was Jack not Edward who took over his father's estate and made himself the head of the family much to the resentment of his brother who was also a lawyer.

In view of this unusual oedipal history it is not surprising that Jack showed a façade of unusual self inflation and grandiosity. He believed that he had greater talent and could do everything better than anyone else and would criticize and belittle everyone's achievements. He felt invincible born under a lucky star. Jack's grandiosity reflected his mother's boundless overestimation of her son who had received her worship and love like a gift from heaven not for his values but for his good looks and charm. She had expected him to be a girl but accepted him because he was so very beautiful. Jack seems to have easily fallen in with his assigned role of a boy who was as lovely as a girl. Remembering Jack's attitude toward his child we can readily see that he repeated his mother's fantasy about himself: he treated his daughter as a beautiful girl who was as active as a boy. Supported by his mother's overanxiousness and protectiveness Jack avoided boyish activities, kept neat and clean and conscious of his charms, used them cleverly first with his parents, later with teachers and superiors and eventually with women. He developed into a handsome, lazy, superficial young man who would spend his father's money generously on food, clothes and pleasures. His good appearance made him very attractive to women. In his late adolescence he began to have affairs and led a rather promiscuous sex life for several years. His first sexual cravings turned to older women. He despised young girls but permitted them to adore him. His first mistress was a beautiful married woman some years his senior who worshipped him while he never cared for her personally. Like his wife's first husband her husband was also impotent. Jack impregnated her once but let her have an abortion and pay for it, too. He explained his behavior by assuring me that she loved me so much she would not let me pay.

In the early twenties Jack's success ended when he contracted a mild tuber-

culosis After his recovery, he had become rather fat, was losing his hair and looked older than his age Most of his attractiveness was gone Jack was severely disturbed He felt his sickness to be a punishment for the kind of life he had led He decided to make great efforts to fight his laziness, superficiality and selfishness, to turn "serious," to work hard like Edward and his father, to settle down, marry and have children From then on his life had been a constant struggle between his conflicting trends After his father's death, his conflicts increased Being the head of both his own and his wife's neurotic family was a burden that he could not carry Jack tried to maintain his grandiose facade and his optimistic opinion of himself But whenever he experienced frustration and failure, he would feel utterly helpless and defeated Then his severe feelings of guilt and inferiority would come to the fore He would accuse himself of being a cheat and a fraud, of having only played the big man while evading true competition and achieving success merely by means of his charm, his looks and his smartness Since his attractions had faded, there was nothing left. Actually, Jack was still a good looking man of above average intelligence and competence in his field

The tubercular infection which had deprived Jack of his greatest asset, his youthful beauty, appeared to have been a turning point in his life But, actually, Jack had always paid dearly for his triumphs The tuberculosis was only one in a series of somatic and psychosomatic illnesses from which Jack had suffered during his whole life All his own previous and present disturbances and worries about his own health were reverberated in the hypochondriacal fears which he developed about his baby The history of his psychosomatic symptoms is striking, showing at first glance, as it were their origin in his rivalry struggle for his mother's love

During his childhood Jack had suffered from recurrent sore throats which his physician had regarded as "mostly imaginary" Preceded by a diphtheria between two and three, the sore throats had started at the age of five after the birth of his younger brother Fred Jack had a complete amnesia about this event All he remembered was that his mother had rejected this child—just as much as Edward—because he was such an ugly baby and a boy

Besides these sore throats Jack had gone through several childhood diseases He complained that Edward had always given them to him after contracting them "from his dirty friends" In puberty, both boys had mumps from which Edward recovered easily while Jack got a testiculitis resulting in the sterility of one testicle After the arrival of another younger sibling a daughter, when Jack was fifteen years old, he began to develop a gastrointestinal disturbance He was convinced he had a bleeding ulcer, but nothing was found His tuberculosis, which started with a hemorrhage, came at the peak of his premarital affairs which had twice led to abortions After his father's death of a coronary Jack began to complain of coronary symptoms and showed anxieties about having a heart disease At present Jack still suffers from occasional sore throats and from gastrointestinal troubles whenever he is upset His coronary symptoms have disappeared

The amnesia which covers the arrival of his younger brother has not yet been lifted But much could be reconstructed from the analytic material referring to his wife's pregnancy to his baby and to the pregnancy of his mother

when he was fifteen—a period which he had also repressed to an amazing extent Jack remembered that his mother prior to her pregnancy had herself suffered from gastrointestinal and menstrual disturbances. Pregnancy had supposedly been suggested by the physician as a cure. Jack's father had warmly endorsed the suggestion while mother had rejected a pregnancy. When it happened she wished to have an abortion but yielded at last to her husband's wishes.

These events occurring in Jack's adolescence the period of beginning adult sex life stirred up all of his oedipal and preoedipal childhood conflicts. Afraid of the disapproval of his mother who had frankly expressed to him her abhorrence of sex Jack had abstained from sexual activities prior to her pregnancy. He had been—or rather pretended to be—disinterested in girls and had masturbated rarely. He looked down with contempt on Edward's first sexual affairs and was disgusted when he surprised Edward seducing a young cousin who lived in their home. Probably Jack had unconsciously managed to surprise his brother since from puberty on he had tried eagerly to pry into his parents' sexual life. He interpreted several scenes which he had overheard as sexual assaults by his father which his mother loathed and related them to her severe menstrual bleedings prior to her last pregnancy. (He had discovered his mother's bloody napkins already in his earliest childhood between three and five.) When the question of another pregnancy of his wife arose Jack re-enacted these fantasies and fears. He was afraid of having intercourse when his wife was close to her menstrual period. Intercourse might induce menstruation reactivate her infection lead to his reinfection and ruin the chance of pregnancy.

No doubt his mother's unwillingness to be impregnated and her plan to undergo an abortion had coincided with his own wishes. As in his early childhood his mother's obvious rejection of a child by the father had made it easy for him to deny his own guilt and project it onto his father. It was not he but his father who was actually responsible for the mother's predicament for her illnesses the pregnancy and the planned abortion. Nor had it been Jack but probably his wife's first husband who had infected her and was responsible for all their trouble. In his adolescence his projective defense showed up in resentful complaints about his father who at the time of the mother's pregnancy had lost a good deal of his money. Jack blamed him for unwise financial transactions which had ruined the family. He imagined that he a boy of fifteen with his greater vision and better business mind could have saved their fortune. In fact he later on increased it considerably by clever business transactions. His grandiose conviction shared by his mother that he was the family rescuer deserving to be the head of the family beautifully reflects his underlying fantasy that his mother would have preferred to have a child from him. Such a pregnancy would have been a real cure. It would have restored her genital which had been harmed by his father. However his view that his father had financially ruined the whole family that is his mother and himself betrays his unconscious masochistic identification with his pregnant—i.e. castrated—mother. It came to the fore in fantasies about his wife's and his own infection. He experienced it as a retaliative action by the deserted first husband who had supposedly given the infection to his wife and to him and had made them both childless.

Jack had developed the same idea with regard to his earlier mumps infection which he had contracted from Edward. He remembered vividly his mother anxiously questioning the physician whether his testiculitis might sterilize him. He felt that Edward had glowered at this potential damage which would punish him for his exceptional incestuous relationship with the mother. In his testiculitis Jack felt identified with his wife's ovarietis.

We understand Jack's original fantasy that both he and his mother had been genitally harmed by the father as a common punishment for cheating him and his other son. Consequently, Jack reacted to his mother's pregnancy conflicts by developing the same gastrointestinal disturbances as his mother, and with fears of getting a bleeding ulcer.

The fact was that his mother did not interrupt her pregnancy but bore the child who, being at last a daughter, was gladly accepted not only by his father but also by his mother. This unexpected outcome had been a severe blow which turned his ambivalence and his projection mechanism back from man to woman. He felt cheated and fooled by his mother and, for the first time, rejected by both his father and his mother in favor of the little girl. When Jack brought up the corresponding material, he accused all women of wanting to make men impotent because of envy of their penis. He interpreted his mother's and other wives' pregnancies as unconsciously hostile actions, aiming at depriving men of their penes. He blamed them, in the same paranoid manner, for unconsciously wanting to ruin their children out of hate of their husbands. He interpreted little mistakes in his wife's handling of his daughter as wishes to harm and kill "his child" and accused his mother of having turned his brothers' hate onto him by treating them so badly. As he had previously denied his own guilt and fastened it on men, so he would now pin it on women. It was not he but his mother who had harmed his father and brothers, it was she who had seduced him and rejected his rivals, she who had wanted to kill her youngest child by having an abortion. He even blamed his mother for the death of his father whom she had upset by a business talk which supposedly had caused a fatal relapse. It may be interjected that Jack had rushed home to take care of his sick father but managed to engage a nurse who was his mistress at the time and to have intercourse with her in the room adjacent to his father's who died soon after. Some time later, he made a trip with his mother, shared her bedroom and kissing her good night, had an ejaculation which his mother noticed and accepted kindly. We can imagine the amount of guilt aroused by these actions. Consequently, his masochistic identification with his father manifested itself in coronary spasms and fears of death which would regularly develop when he had business talks with his mother dealing with his father's estate.

It was after the birth of his sister that Jack's rebellion against both parents had broken through as open competition on all levels and with all of them: father, mother and the baby. During this period he developed in the most exaggerated way the defenses discussed in the first part of the paper. He fathered and mothered his sister who became so overattached to him that at present she has difficulty in getting married because she cannot find a husband as wonderful as her brother Jack. Jack blames his mother for her bad influence on

the girl and his father for having spoiled her. He had to rescue his sister by sending her to an analyst. While he showed exaggerated love and protectiveness toward his baby sister—reminiscent of his present affection for his little daughter—he had tried to seduce not only her nurse and soon after a woman friend of his mother who had borne a child but also the nurse of her baby. Somewhat later, he seduced the above mentioned married woman, refused to marry her, impregnated her, let her have an abortion and pay for it, and then deserted her. This was the period when he contracted his tuberculosis which started with a hemorrhage. It was a punishment for his sins and at the same time a masochistic identification with the pregnant or aborting woman as well as with the baby. In fact he succeeded in getting his mother to nurse him and baby him along through several months of his rest cure during which time she had to desert her family for his sake.

As to his rivalry with his own baby, Jack abstained from intercourse during her nursing period, afraid that he might squeeze his wife's breast and thereby stop her milk flow. Though craving for large breasted women, he had always been scared of kissing breasts which he regarded as a dangerous source of infection. He believed that he would get sore throats from kissing them and that he had probably contracted his tuberculosis in this manner. This leads us back to his earliest psychosomatic manifestations, the sore throats and fear of infection which had begun at the age of five after the birth of his youngest brother. Analysis showed these symptoms to be paranoid distortions of his earliest preoedipal fantasies. These fantasies represented condensations of desires to be a baby and to be nursed by his mother with desires to have a baby either by incorporation and reproduction of his mother's breasts or his father's penis.

When the problem of a second pregnancy of his wife arose, Jack developed a preference for fellatio while accusing his wife of taking anything dirty into her mouth, of biting her nails, and of almost biting off his penis. After his defenses had broken down, it became apparent that his own fellatio wishes represented the desire to get pregnant by biting off man's penis. Eventually sadistic impulses toward his wife's breasts and a longing to perform cunnilingus broke through simultaneously with food idiosyncrasies, violent gastrointestinal reactions and fears of being poisoned. This was the time when his wife had again become pregnant. It became clear that her pregnancy had shifted Jack's homosexual pregnancy fantasies and fears back to her. His cunnilingus fantasies could be understood as desire to get the child back from her—i.e. to recover the father's penis of which the mother had robbed him—by eating it up and either destroying it or rescuing or reproducing it as a baby.

Jack's material illustrates the little boy's preoedipal pregnancy and birth fantasies which were described in the first part of this paper. They show the preoedipal equation of breast, penis, pregnant womb (intestines) and baby as mentioned above.

We can easily understand the enormous ambivalence struggle about his child which reflected itself in his neurotic attitudes, his symptoms and his fears.

Since the case of Jack is too complex for a short summary, I wish to end the paper by discussing briefly how Jack had used his mother's pregnancy for

a neurotic solution of his castration conflict. The discovery of his mother's menstruation between three and five had been a severe castration shock which was repeated in adolescence when his mother suffered from serious menorrhagies. Her subsequent pregnancies lent themselves to a denial of female castrations. They represented "a cure," i.e., a restitution of the harmed female genital. According to the above mentioned fantasies, however, pregnancy came about by incorporation of the father's penis, with which the baby was equated. This concept reversed the roles: it restored the image of the phallic—as equated with pregnant—mother, but turned men into castrated beings. His mother's rejection of his father and brothers confirmed this concept and lent itself to his identification with her as with a phallic woman, i.e., a woman who grows babies. By ousting his father and his brothers from their positions, however, he had not only castrated and eliminated his rivals but deprived his mother of her penis substitutes. Consequently, he had to offer himself to his mother as a recompense, as her own ideal and the only acceptable and aggrandized penis substitute. As he put it himself: "He made himself 'her beautiful little girl but with a penis'." And his mother accepted him gladly in this role and loved him as the ideal part of herself. Jack had paid for this triumph with a fatal identification with, and dependency on, his mother, resulting in severe symptoms which developed whenever female castration impressed itself on him. In his adolescence, after his sister's birth, Jack had tried to tear himself away from his mother and to assert himself in a masculine position. His attempts had failed. His marital experiences, the castrative infection of his wife and of himself which seemed to make them childless, rearoused all his infantile conflicts, broke down his defenses, produced severe castration fears and precipitated a serious neurotic condition. The arrival of his child, far from curing him—and his wife—as he had thought, succeeded only in displacing his castration conflict onto his baby. This resulted in even more blatant symptoms relating to the child.

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ON MASTURBATION AND ITS INFLUENCE ON GENERAL DEVELOPMENT

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I

In 1912, the Viennese Psychoanalytic Society published a symposium on the topic of 'Onanism' (4). Professor Freud concluded his own contribution with the statement 'We all are of the same opinion, that the subject of onanism is inexhaustible'. Today, after a lapse of thirty eight years, I think this statement is still valid. However, we may be able to contribute some additional information to some of the outstanding points in the 1912 discussion.

Freud summarizes, among other things, those points on which there existed a general consensus among the discussants and those on which opinions differed.

The discussants agreed

- (a) on the importance and meaning of the fantasies accompanying or replacing masturbation,
- (b) on the importance of the guilt feelings connected with onanism.

Today we can confirm these findings; moreover we are now better informed concerning the origin, development, and fate of the fantasies.

One of the points on which at that time opinions differed concerned the origin of the guilt feelings. This particular uncertainty has since disappeared: the various sources of the guilt feeling are now rather well known to us.

The rest of the differences in opinion at that time centered, to be exact, around the one question: Can the masturbatory activity per se be harmful? This question was answered more or less passionately, by some discussants in the affirmative, by others in the negative as regards any direct somatic impairment.

To Freud, who belonged to the first group, this problem was intimately connected with his concept of the actual neurosis. Freud maintained his first conception that a number of neurotic symptoms were caused by the toxic effects of undischarged or inadequately discharged quantities of instinctual energy and thus created a nucleus for the psychoneuroses, caused by psychological conflicts.

The symptoms of neurasthenia—constipation, headaches, fatigue—were thought to be the consequence of (excessive) masturbation, the anxiety neurosis actually a remaining part of the undischarged coitus excitation. In the discussion at that time, Freud retracted his original idea that the actual symptoms could not be influenced by psychoanalytic treatment. However he then considered the cure of those symptoms as a secondary effect of the treatment. He assumed that the psychoanalytic treatment effected a greater tolerance of the actual noxicity or that it enabled the patient, through alteration of the sexual regimen, to avoid these noxicities. At what point and according to what mechanisms the direct organic (toxic) impairments of masturbation occur is not known in Freud's opinion. He also emphasized at that time that one must separate these direct impairments from everything that may be caused indirectly by the ego's resistance and rebellion against this particular sexual activity.

It would be wrong to conclude from these concepts that Freud always considered masturbation a harmful activity although this conclusion frequently has been and may still continue to be drawn. Thus even at that time he pointed out that there are times in analysis when we must consider masturbation as a sign of therapeutic progress. He was referring to those cases as in hysteria or compulsion neurosis with whom having previously repressed masturbation for neurotic reasons it then recurs during treatment.

At present we can neither prove nor disprove the existence of toxic impairment due to masturbation or frustrated excitation. On the one hand we know how important a normal sexual life is for mental health and how greatly periods of life with physiologically increased instinctual demands like puberty and menopause predispose to psychological disturbances. On the other hand our growing psychoanalytic experience has taught us how frequently neurasthenic complaints can be dissolved and how analogous they are in this respect and also in respect to their causation to hysterical or psychoneurotic symptoms.

It may be that today the question of whether instinctual (sexual) energy could have a toxic effect (on the psyche) has lost its importance.

The investigation of the interaction between psychic and somatic disturbances has been very much in the foreground. It appears that certain organic pathological manifestations asthma nervosum colitis ulcerosa ulcus ventriculi skin diseases hay fever, etc., may be caused by psychological conflicts similar to those underlying various psychoneurotic symptoms. Some of these somatic complaints have even been influenced indeed cured by psychoanalytic treatment (psychosomatic medicine). Careful observation has shown the frequency even in healthy individuals of organic reactions to psychological stimuli—reactions for instance of the vascular

system, of the intestinal tract, of the sensory apparatus. On the other hand, we have to presume an organic correlate as basis for all psychic processes, even if its existence cannot be proven directly. It is improbable that this organic correlate is to be looked for only in the manifestations of sexuality. I will not elaborate on this interesting topic, nor on the hopeful expectation that somatic and psychological therapy will be combined to an even greater extent, when in the future our information about these interactions will more and more increase.

I will return now to the subject of masturbation. I want to emphasize that so far my remarks referred to the masturbation of adult individuals. By masturbation I meant any manipulation of the genital apparatus (or of erogenous zones substituting for it) for the purpose of gaining pleasure. But we have to take into consideration that generally masturbation is indulged in since early childhood, at a time when any other discharge of instinctual tension is not yet possible because of physical and psychological immaturity. It has been ascertained that *all* children masturbate during their first years of life, that *most* of them masturbate during puberty and that masturbation sometimes occurs during the latency period as well. By this means sexual as well as aggressive instinctual excitations are discharged.

I think we may describe masturbation as a normal activity of childhood for the purpose of discharging instinctual tension. It may fulfill the same function with adolescents or adults whenever the instinctual gratification of a physical and emotional relationship with a lover is not or not yet possible in a form more appropriate to adult age. In the so-called civilized societies the latter situation occurs frequently, because the individuals usually have reached sexual maturation physically and mentally, long before it is made possible for them to satisfy their emotional love needs in a permanent relationship and in the foundation of a family.

Masturbation may be accompanied or followed by neurotic disturbances of many kinds. There may be physical (neurasthenic) or emotional symptoms. The latter may consist of depressions, nosophobias, inferiority or guilt feelings, or self-torment. But whatever these manifestations, we are certain that the masturbatory act did not cause them but that we are dealing with neurotics who, as we know from psychoanalysis, acquired their disharmonies in early childhood and now connect their complaints with the masturbatory act. Therefore there is no sense in limiting the meaning of masturbation either in psychology or in psychopathology to the physical manipulations of the genitals or of the substituting erogenous zones. The decisive factor for health or sickness lies in the conscious or unconscious fantasies, feelings (guilt feelings) and impulses which accompany the masturbatory act.

This brings us to the two points mentioned above on which, according to Freud's summary, there existed a consensus of opinion among the Viennese discussants. However, we want to add that masturbation fantasies and (guilt) feelings not only are of importance but are of *essential* significance for the psychic life.

Among the Viennese participants, Stekel more than anyone else argued against the concept of the injuriousness of masturbation. We are in accord with him as far as the physical actions are concerned.

On the other hand we definitely dispute his statement that 'all people masturbate' even if we take into consideration that Stekel includes herewith the disguised forms of masturbation. Emotionally healthy grown ups will seek means and ways (and will usually find them), to satisfy their sexual needs in a normal love relation with a partner; they may occasionally use masturbation but only temporarily in periods of transition. Adults, who *permanently* resort to masturbation (whether they choose it as exclusive form of satisfaction or retain it in addition to sexual intercourse) are individuals more or less disturbed in their development, who remained fixated to that infantile form of sexual activity.

II

I now want to turn our attention to the psychological manifestations accompanying masturbation and trace certain vicissitudes of these fantasies, impulses and emotions. Let me emphasize again that, when I speak of masturbation in what follows, I am referring to the *whole complex* of physical and emotional manifestations. We will see that both components may join in following the same path or they may also be separated. Wherever this separation occurs, psychoanalysis can always demonstrate that in the unconscious they belong together.

Masturbation, especially in young people, often gives rise to an oppressive burden of emotions. Feelings of anxiety, guilt, sin, inferiority and depravity as well as fears of sickness, insanity, spinal disease, impotence, etc., may all be connected with masturbation.

It is well known that a very important source of all these horrors lies in various layers of society, in the attitude of those responsible for the child's upbringing (*Erziehungspersonen*). Parents, teachers, clerics and often doctors also, in speech and writings, often very forcefully, attempt to convince the young that masturbation is the most dangerous and sinful of vices.

Yet it is remarkable that in spite of these ominous threats and punishments so many people finally attain a normal sexual life. Whether in defiance of all intimidation they continue masturbation until they achieve

adult sexuality with a partner, or whether they give it up, the end result can be a healthy love life

On the other hand there is a frighteningly large number of individuals who react to these prohibitions and threats with mild or severe psychological disturbances. One encounters cases which range all the way from mild disturbances of potency, inhibitions or difficulties of adjustment to severest impotence, neurosis and impediments of development. Where there is no severe impairment frequently simple reassurance about the harmlessness of the activity and enlightenment in case of ignorance may produce relief and may lead the development into normal channels.

However, where such a procedure is of no avail it is evident that the intimidations of the environment were not the sole cause of the neurotic illness, but that they effected an already sick or disturbed individual and that one has to seek for the causes in the childhood.

Masturbation, as is well known already occurs during infancy. The infant plays with or rubs different parts of his body. In the beginning the mouth zone plays a very important role, sometimes perhaps in consequence of feeding, i.e., through stimulation by the breast or bottle. However, according to a number of observations by physicians and nurses some infants even before the first feeding suck their finger which may lead to a facial expression of satisfaction and to quietly falling asleep. The sucking reflex seems to point the direction here. After some time various other body zones are rubbed and finally also the genitalia. Some observations on infants up to the age of one seem to indicate that a kind of acme may be reached which could be considered as an early infantile form of orgasm. Perhaps more frequently this playing is quiet and uninterrupted which seems to lead to a diffuse kind of satisfaction. In Spitz's interesting and important article 'Autoerotism' in which he records observations on 196 infants between the ages of 0—15 months he calls such activity 'genital play' instead of masturbation (13).

A widespread opinion already represented in the Viennese discussion in 1912 contends that the bodily care of the infant is the effect of a seduction by the mother or nurse and that the child is led to genital activity in this way. In contrast to this view Spitz believes that it is not the physical rubbing or friction which teaches the child the genital play but the emotional relation to the mother (13).

I agree with the author when he writes in the introduction of his paper: "A really unimpeachable study would have to offer continuous 24-hour observation of the infant during the whole of the first year of life" (13 p. 85). Also it seems to me that his experimental conditions—the observation of each child at weekly intervals and only during 4 hours per week, are very far removed from the mentioned ideal conditions. I there-

fore think that the conclusions and hypotheses of Spitz, interesting as they appear to be, should be viewed with the greatest caution and that many observations under more favorable conditions will be necessary to give them validity. Thus for instance, I question whether the autoerotic gratification of rocking only occurs because the child is unable to establish an object relationship due to the inconsistent, contradictory behavior of the mother. From a few but intensive observations I gained the impression that rocking also occurs with a strong object relationship (The latter can be neurotically tinged on the mother's part).

On the other hand it is a tempting hypothesis to assume that the infant's activity and thereby also its genital play is not only learned through mechanical stimulation but that the emotional relationship to the mother (or mother substitution) is an indispensable factor. It seems certain that infants treated without love (even though adequately nourished) deteriorate physically and are psychologically hampered in their development as well. Intelligence, emotional life, motility, instinctual life and ego functions are interfered with in their maturation processes and show more or less retardation. From his observations, Spitz concludes:

When this (the mother-child) interrelation is at its best, genital play will be general in the first year of life and general development will surpass the average (13, p. 103). This is marvelously in accordance with Freud's concept, laid down in 1905 in his *Three Contributions to the Theory of Sex*.

In the chapter on object choice, Freud describes that every object choice of the adult is a re-finding and a continuation of the relationship of the infant to the mother (nurse) who not only stimulates and satisfies the child through his erogenous zones but also supplies him with emotions which originate in her own sexual life, etc. And further: As we know, however, the sexual instinct is not aroused only by direct excitation of the genital zone. What we call affection will unfailingly show its effects one day on the genital zones as well. Moreover, if the mother understood more of the high importance of the part played by instincts in mental life as a whole—in all its ethical and psychic achievements—she would spare herself any self-reproaches after her enlightenment. She is only fulfilling her task in teaching the child to love. After all, he is meant to grow up into a strong and capable person with vigorous sexual needs and to accomplish during his life all the things that human beings are urged to do by their instincts (8, p. 100).

Whether it results in an acme or in a diffuse gratification, masturbation has a normal part in the development of a healthy infant's instinctual life as well as supplying it with pleasurable activity of various bodily zones. A good loving attachment (close relationship) is a precondition for

a sound development Which form this mother relationship takes is a different question The emotional attachment develops gradually out of the biological, physical, mother-child unit Just when or how this occurs, is, in my opinion, still unknown

Melanie Klein concludes from her numerous and particularly impressive observations that during his first weeks of life, the infant already forms a wealth of complicated fantasies of a loving as well as an aggressive nature According to Klein, the infant wants to possess the mother, wants to penetrate her, wants to incorporate her and to dismember her, to rob her and to destroy her depending on his feelings about the mother as a good or 'bad' object. The infant then supposedly is tormented by guilt feelings because of his bad fantasies and already during the first months of life has a severe and punitive superego(10)

It seems to me a large and arbitrary step to conclude that all these complicated fantasies are already present in the infant, merely from the observations that satiated and contented infants smile at their mothers and that hungry ones or those suffering from painful sensations scream, struggle or show expressions to be interpreted as anxious It seems much more plausible to assume that intense primitive excitations sensations and impulses may exist in the infant which may be directed toward the mother, but that these are only elaborated into complicated psychic formations as the above mentioned fantasies after the psychic apparatus reached a certain level of development We are aware that such excitations and impulses also exist in domesticated animals without concluding that they form similar fantasies The ego development has not yet begun in the newborn child even though an innate nucleus of the ego exists It still takes a rather long time before the infant develops his ego functions and before he is able to achieve an even primitive coordination of some of these functions However only after such an achievement is one justified in speaking of a primitive ego The differentiation in the ego, which leads to the formation of the superego belongs to an even later phase of maturation

To make a simple equation between primitive id impulses and psychic formations involving ego and superego hardly seems a service to scientific attempts at clarification This method ignores the fact that psychic life undergoes a process of development—of dynamic maturation However, it would be premature to postulate more exact data for the individual stages of development Let us console ourselves with the fact that many more thorough observations will be necessary for the clarification of these conditions

However that may be we may assume that the infant in his first year of life provides pleasure and gratification for himself by playing with various parts of his body, and that in this gratification the genitalia have

an important role. Moreover this gratification is closely connected with the mother child relationship which accompanies and shapes the child's entire development.

When at the end of his first and in his second year the child enters the anal phase of libidinal development, this playing begins to be concentrated on the anal zone and its productions. It is quite certain that a high intensity of instinctual energy is disposed of here. But genital play and the stimulation of other body zones frequently continue during this period as they did during the preceding oral phase, although perhaps with less intensity. It is well known that Freud's classification of the three phases of infantile libidinal development is schematized and that an overlapping of the different phases occurs with remainders of earlier phases coexisting with elements of later phases to a greater or lesser degree. In the final phase of the early libidinal development, the phallic phase the instinctual discharge occurs primarily via the genital zone. The sexual activity of the child now reaches its peak in masturbation which may be accompanied by erections and which frequently culminate in an acme.

The fantasy activity, in the meantime, blossomed out together with the entire infantile personality. Intelligence, many ego functions, the forerunners of superego in ideal formation and moral demands have taken shape. The child has learned to differentiate between his self and the environment to a greater or lesser degree. He has gathered knowledge of the external world and has developed a reality sense which sometimes is still incomplete, but which is frequently amazingly correct and keen. The fantasy life as expression of intense instinctual and emotional strivings has followed its own course of development. That does not mean that the elementary force of the instincts has not exerted great influence upon the infantile ego development. This influence may be a stimulus. Thus for instance, the awakened sexual curiosity may lead to efforts of exploration and discovery which may foster the knowledge of reality. The child's power drive arouses the desire to be big and in his rivalry with the grown ups may support his intellectual unfolding and his desire to learn.

However, if for external or internal reasons the fantasy life constitutes a danger, a reverse influence may occur, resulting in an inhibiting and sometimes even destructive effect on the entire ego development.

It is well known that this second outcome occurs only too often first, because of the frequent and severe condemnation and punishment of infantile masturbation by persons in charge of the child. On the other hand as a result of the many instinctual and emotional conflicts to which the child is exposed. As a consequence of these experiences we

encounter neurotic disturbances inhibitions of development and character deformities Before we take up the fate of the masturbatory activity and of the fantasies which initially at least accompanied them we will first say something more about the origin and content of fantasies during the anal and phallic phase

The child's fantasies become well known to us as soon as he is able to verbalize them This scarcely occurs before the age of one and a half or two years even if one has learned to understand the child's primitive language Yet we can hardly question the existence of a form of representation without words This is proved by adult dreams in which desires impulses and emotional strivings find a plastic representation We have learned from Freud's *Interpretation of Dreams* that this representation is an archaic one belonging to the primary process(5) The primary process is the psychic mechanism which dominates the psychic life of the young child before he is able to develop the secondary process In addition the one year old child who already has developed certain psychological and physical abilities but not the ability to verbalize demonstrates in his play and actions manifestations which we can only interpret as expressions of desires followed by symbolic gratification In place of many illustrations I only have to cite Freud's observation of child play which he describes in *Beyond the Pleasure Principle*(7) This description also shows us the difficulty of interpreting such play and how cautious one has to be in interpretation since it is probable that many different impulses are discharged in a single action The affectively charged games and activities of the one or two year old child must be considered as the predecessors of fantasies at a later period which in the phallic phase are known to us as oedipal fantasies Sometimes we are able to follow them through the latency period and watch them break through again with great intensity in puberty even though they have been modified by development and the broadening of the world of experience

Verbalized fantasies have become a dependable source of psychoanalytic knowledge Sometimes the psychoanalytic treatment of adults yields us deep insight into the primitive forerunners of the fantasy world of the child When a patient during the psychoanalytic session temporarily renounces his adulthood and presents the attitude mimic behavior crying struggling and stammering of a young child he re-experiences often with intense vividness the impulses and sensations of this archaic period Such an acting out resembles a real psychotic episode The disadvantage of these observations during treatment in psychoanalysis compared with the direct observation of children lies in the difficulty of differentiating early from later material this sometimes may represent a special technical task However the inner conviction with which after

this acting out, some patients are able to account for that immediate emotional experience is a valuable confirmation (or correction) and a pointer for the further task. The young child, of course, is unable to give such an account. Therefore the child observer lacks an important instrument for evaluating the correctness of his interpretations.

Let us now try to collect whatever we know so far about these primitive predecessors of fantasy life. From the beginning the child tries to get rid of unpleasant bodily tensions which are connected with imperative bodily needs (need for nourishment, excremental needs etc.) and which soon are accompanied by psychic tensions or cause these tensions. Sexual and aggressive drives take part in it: passive and active strivings coexist; the impulses are awakened in the mother-child relationship and aim at the one and only object, the mother or her substitute. In rough outline there is a primacy of focus shifting in succession from the mouth to the anal and finally the genital zone—although during all these phases there is also activity on various other parts of the body. Finally this whole complex of excitations, impulses and emotions merges into the (relative) end phase of the oedipal constellation of instincts and emotions. This oedipal constellation leads to the whole personality a more or less stable structure, a pattern for the final shaping of the personality in adolescence.

In normal development the oedipus complex is distinguished by the fact that genital masturbation has become the only (or almost only) act of autoerotic gratification. At this point a boy's desires and instinctual impulses are expressed in fantasies whose abbreviated content is: I want to take father's place with mother. The comparative simplicity of the strivings and fantasies in the oedipal situation is in contrast to the manifold diffuse impulses, strivings and aims of the preoedipal period. However, on close inspection we notice that a great number of manifestations of the preceding period are preserved in more or less disguised form by the youthful oedipus. These are just the ones which come to the fore in the infantile acting out of the patient during the psychoanalytic situation described above. Most striking are the strivings and desires with passive aim. The child desires to receive everything passively from the mother, not only to be fed but also physical gratifications in forms of caresses, fondling, affection and admiration, and all this with a child's well-known insatiability as the exclusive love object of the mother. These passive desires may be expressed in oral, anal and phallic fantasies. During or after the oedipal phase these passive fantasies are displaced from the mother onto the father. Thus the passive feminine father relationship (negative oedipus complex) develops in the boy; whereas in the girl it leads to the normal positive oedipus constellation which serves as pattern for her later grown-up femininity. Strangely enough active as well as passive fantasies are discharged through masturbation.

Abraham in 1924 pointed out that in each of the three developmental phases one may distinguish two chronologically separate tendencies toward the object. These are the tendency to take in and to retain and its opposite, the tendency to expel and to destroy. They represent the instinctual and emotional ambivalence (libido-aggression and love-hatred). (1) Abraham's work has greatly enhanced our understanding of the development of the child and of pathological conditions like melancholia, mania, compulsion neurosis and paranoia. However, I believe that at that time not enough attention was paid to the coexistence of active and passive strivings. I also believe that in consequence the chronological succession, postulated by Abraham, becomes a schematization which does not completely correspond to observations. Tendencies to (passive) incorporation and (active) ejection always exist simultaneously during all three phases, although in individually different intensities.

In the newborn we find together with the passive tendency to be nursed an also clearly noticeable active tendency to search for the breast, to take possession of it and to suck. Even in the newborn one observes strong differences in constitutional activity and passivity. Furthermore, the personality and attitude of the mother—the other partner of the initial mother-child unit—has, of course, great influence on the further development of these strivings. Also during the anal phase active and passive attitudes coexist rather than succeed each other. One is always surprised anew by the observation that in the psychic life passive experiences precipitate activity and active attitudes are followed by passive desires. Keen observation of healthy adults reveals that they too show a succession of these alternating tendencies which are immediately evident in pathological conditions (most extreme in the manic depressive).

The child's activity is initially to a large extent still an expression of instinctual ambivalence, i.e., discharge of the unsublimated aggressive or destructive drive, especially where it has been awakened by the frustration of passive desires (The tendency to destroy the object in the cannibalistic and in the first part of the anal phase as described by Abraham).

The combining of aggression and libido and the sublimation of both drives results in the postambivalent phase, that of object relationship which Abraham presupposes, albeit as an ideal, for the final genital phase.

Marie Bonaparte in her three papers, *De la sexualité de la femme*,² broadens Abraham's scheme of the early infantile instinctual development by giving great importance to the passive and active instinctual aims.⁽²⁾

Her extensive and very interesting report on female sexuality is particularly valuable. But in her description of early childhood processes, Marie Bonaparte likewise presents as a chronological succession what, in

my opinion, exists simultaneously. Though she acknowledges the phallic activity of the little girl, Marie Bonaparte believes that the girl passes through a preceding passive phase during which she experiences pleasure sensations at the anal zone (called by the author 'cloacal zone' in analogy to the biological embryonal development). The author also believes that these sensations attain a special feminine character through the fact that during clitoral masturbation the girl often accidentally reaches the introitus and thus becomes acquainted with her own vagina.

I agree with Marie Bonaparte that little girls may masturbate at the introitus and labia minora more often than had previously been assumed by Freud. We know that reddening and catarrh of the introitus have been observed in little girls and may have been caused by masturbation. However, it seems questionable to me whether these observations should be evaluated differently from similar anal play of the boy. It is absolutely certain that children of both sexes develop the most active aggressive games and fantasies with the anal gratification one could say with anal masturbation or masturbation of the introitus or of the labia. We also know that in the oedipal or post-oedipal period, strongly passive masochistic fantasies are discharged through penis—or clitoris—masturbation. I believe it is misleading to equate in a child vaginal masturbation with passivity or femininity and to identify phallic masturbation exclusively with activity and masculinity.

It seems improbable to me that a little girl is ever able to reach the fundus of her vagina at which the real orgasm of the adult woman originates. But even if this should occur sometimes, for instance after seduction, it has little significance in regard to the passivity or activity of the child's fantasies or experience. Passive and active forms of experience accompany the physical masturbatory activities of children of both sexes throughout the three main phases of development before the genitalia actually take over the primacy. In normal development, it is only after the recognition of the sex difference has had its effect, that the active (penetrating) desire is tied to the male and the passive (receptive) desire is associated with the female organ. This occurs after the castration complex has taken effect. For the boy the passive receptive organ is the "hole" which he has seen in the girl and which, in accordance with his anatomic knowledge and his own experience, can only be the anus. For the little girl it may be anus, labia or introitus but never the fundus vaginae.

Although the parallel drawn by Abraham between psychological and embryological physical development (a parallel also assumed by Marie Bonaparte) is very interesting, one must not draw it too far.

In the first place, by the time psychic life begins the sex of the individual has long since been physically established. Secondly the develop-

ment of the highly complicated psychic processes is influenced by so many internal and external factors that it quite certainly also follows a course of its own.

To prevent misunderstandings I want to stress that it is far from my intention to prove that little boys and girls are identical in their psychological make-up. While the ratio between active and passive strivings varies in each individual, it also certainly varies normally more in favor of activity in the male, and more in favor of passivity in the female child. Nor may one underestimate the importance of the parents' attitude. The mother ordinarily seeks to foster masculinity in the son, the father, femininity in the little daughter. However, in my experience the shaping of the sex does not take place in the individual child before the peak of the oedipal constellation has been reached. This is the very point when the development of boys and girls part ways. In the boy the active sexual strivings will become victorious and passivity will be sublimated and becomes socially applied (of course, together with that part of activity which is withdrawn from direct sexual life). In the girl, activity is subordinated to passivity. Now at the end of the oedipal period, that forceful repression takes place (initiated in the boy under the pressure of castration anxiety) which leads over into the latency period. All the restrictions and prohibitions of instinctual gratification which the child experienced from the mother (later from both parents) now are fused into the one prohibition: you must not masturbate. This prohibition will be introjected and lead to the formation of the punishing part of the superego. The danger of castration as a threat to narcissism, the danger of losing the love of the parents and soon after the love of his own superego, cause the boy to renounce masturbation or at least to reduce it and to repress the accompanying fantasies. If he does not succeed in giving up masturbation, it will be practiced with anxiety and guilt feelings. Frequently the fantasies disappear from consciousness only to maintain a kind of isolated existence in the unconscious. Often, however, the opposite occurs: physical masturbation is renounced but a blossoming fantasy life persists.

The little girl's development runs a different course: the narcissistic injury due to her awareness of her being "castrated" causes enmity to the mother whom she holds responsible for this "defect." Her phallic activity toward her mother becomes displeasurable and she turns toward the father with passive desires. The repression of instinctual life is not as imperatively effective, since castration anxiety is lacking. However the repression-effecting threat of punishment by the parents (and the superego) is strongly reinforced by the very feeling of having an "inferior" genital with which one cannot really masturbate. And thus girls more often give up masturbation during the latency period than do boys. But

then fantasy life (now most frequently directed toward the father) continues to flourish. Yet in girls also masturbation may break through the latency period, and be accompanied by conscious or unconscious fantasies.

Masturbation almost always re-erupts during a boy's puberty, less regularly in that of the girl. The fantasies frequently are real sexual images involving a partner, they also may be prolonged daydreams which begin to resemble stories or novels. Close inspection and analysis reveal more or less clear traces of the early infantile fantasy and impulse life.

I have given only a brief summary of the phallic-oedipal period of both sexes, since this phase and its importance for the adult sexual life have been repeatedly and thoroughly described. I would now like to comment on the various vicissitudes both of the content of fantasies and of the masturbatory act, and finally on the influence of these vicissitudes upon character and personality development.¹

In addition to the oedipal fantasies which are positive and active fantasies of taking possession of the mother, the boy in the phallic phase may also express other, more or less forceful, passive desires toward the father (negative oedipal constellation). These passive feminine (homosexual) strivings, which culminate in the desire to take the mother's place with the father, demand as precondition the renouncing of the penis and are therefore dangerous for the child's masculinity.

If they cannot be sufficiently repressed they frequently seek a way out in the return to the preoedipal object relation, in which the little boy lets himself be loved, taken care of, fondled, caressed, admired, fed, cleaned, even given an enema and nursed by the mother. In this form of passive gratification the danger of castration no longer threatens him. Moreover the mother herself participates intensively in these kinds of gratification, a fact which the child then experiences as permission or even seduction. Naturally, he also experiences many limitations and prohibitions, because the desires of the child are insatiable, and training and education demand adjustment to the norm, restraint, control or renunciation of instinctual impulses altogether. The weaning from the breast, control of excretion, suppression of finger sucking, anal play, aggressive explorations, etc., may arouse anxiety which may become the forerunner of castration anxiety. However, in comparison with castration anxiety which concerns the most highly estimated part of the body, the penis, this anxiety is only mild. The escape into the preoedipal period is mainly fostered by three factors:

- a a comparatively strong passive constitution
- b forceful and extremely severe suppression of instinctual expressions by the parents

¹ On its inhibiting influence which leads to neurosis see (11)

- c. a dominating, aggressive mother who (because of her own penis envy) is not able to tolerate masculine activity in the boy and who seduces him into passive behavior, the child thus representing her own lacking penis which she unconsciously wants to fondle and caress (masturbate)

However, the *active* oedipal desires also may return to the preoedipal phase. Castration threats, experienced or only expected, from the father arouse extremely intense anxiety, if the child's aggressive drive is especially strong. Aggression becomes an internal danger through the attitude of severe parents (or a severe superego) as well as through the ambivalence conflict which makes simultaneous love and hatred, directed toward the same person, gradually intolerable. This aggression has to be suppressed and thus a sublimation of aggression into constructive activity is prevented. The entire development falls back a step and the boy escapes to the preoedipal mother with both his active as well as his passive desires.

The interesting aspect of this is that the drives may or may not take part in this process. Where the drive does take part in some cases a real regression of instincts occurs, whereby (sometimes only gradually) genital masturbation is given up completely and there is recourse to anal, oral or other primitive discharge, sometimes in disguised or displaced forms. This for instance may be the case in compulsion neurosis, where the symptoms, the compulsive acts, may gradually replace masturbation. However, often genital masturbation continues without interruption up to adulthood, but the fantasies find expression in the language of preoedipal desires and experience. One finds this among hysterical neuroses, anxiety conditions and phobias. But what is of greatest interest to us is the mode in which these fantasies, inhibited in their development, are built into the personality structure and into the character formation.

In my paper on "The Pre-oedipal Phase in the Development of the Male Child," I described some forms of the love life of adults who have remained fixated to the preoedipal mother image or who returned to it, while their potency was only mildly disturbed. For instance, men who remained dissatisfied in their marriages and compulsively had to engage in one relationship after the other, frequently are looking for the image of the preoedipal mother of whom they demand the gratification of their infantile desires⁽¹²⁾.

Or men who compulsively devalue and debase their wives may project on them the hatred belonging to the preoedipal ambivalent period, etc. I also mentioned in that paper the influence which the preoedipal mother fixation may have on the superego formation.

In the same way we also can observe that a remaining with or return

ing to the preoedipal fantasy life may inhibit the *ego* (or parts of it) in its development. This leads to the so-called infantile personalities. Sometimes the development of intelligence is not inhibited but some of the *ego* functions may be partially or entirely arrested, as for example, the sense of reality.

An adult who, in his unconscious fantasy, lives to be fed, indulged in and cared for by his mother, expects the same situation in real life, demanding of his environment protection and affectionate handling, and will frequently be unable to realize and to accept the sober reality and the necessity of building an independent life. The final outcome of this inhibition of development depends on the extent to which the sense of reality is impaired. If the greatest part of the *ego* remained in this infantile constellation, a psychotic condition may result. If a part of the reality sense remains intact, adjustment difficulties, inhibition of emotional contact with others, frequently even failure in work and professional life, will result. The objective evaluation of people, situations, political events will be impaired, because the formation of judgment is merely "self-related" and is tinged and distorted by narcissistic needs. A second important factor, which leads to such defective evaluation of the real world lies in the fixation to the emotional ambivalence which is normal for the young child. In harmonious development, aggression and destruction is gradually bound by libido; they are partly sublimated and used for constructive activity toward the external world, partly they are turned inward and used for self-criticism and self-control. If one or several of these mechanisms fail (as in the infant usually stimulated by frustration, disappointment and injury) the aggression may be turned against the external world indiscriminately. Then judgment and critical evaluation of the environment (persons, events and situations) cannot be objective. The "other-one" is bad and worthy only of contempt. From this description we also see that fixation and regression to the world of preoedipal desires likewise inhibits another *ego* function, namely the synthetic (or integrative) one.

When one part of the personality, as for instance the intellectual development, reaches the level of the chronological age but the reality sense and the judgment formation connected with the inhibited emotional development correspond to the age of the young child, a disharmony, sometimes even a split in the personality results.

Even the *ego* function of control and use of the motor apparatus may be impaired if the unconscious fantasy demands the gratification of being an infant with whom the necessary actions are performed by the mother. Some individuals, because of anxiety due to their own aggression, either avoid any motor activity or at least inhibit it.

I have described some of the many inhibitions of development which may be caused by the return to the fantasy life of the preoedipal phase which in the male are due to the unconquerable anxiety of the oedipal situation, that is, to castration anxiety

Similar infantile character formations may be found in the female who may take similar flight to the preoedipal mother. As we have said before, in the female the cause of this flight is not castration anxiety. It is the concurrence of her oedipal disappointment in the father with a some times insuperable narcissistic injury caused by her awareness of her own genitalia which she considers defective

This is the point, as mentioned before, at which the development of the two sexes takes radically different directions. Sex differences may have been noticeable before this time so far as differences in emphasis and intensity between active and passive attitudes went but neither the physical modes of gratification nor the fantasies showed essential differences

Since I wish at this point to elaborate once more the different vicissitudes of the masturbatory act in boys and girls respectively, I have to make a brief recapitulation

During latency period the boy rarely gives up masturbation completely. Masturbation will be suppressed, on the one hand, due to the comparative calm of the instinctual life, on the other hand, due to the anxiety caused by the forbidden incestual desires. But from time to time a discharge of the sexual urges through the masturbatory act may occur. The fantasies are concerned with being big and grown up. In the center of the fantasies is the ambition to be a powerful man both in a heroic love life and in all other life situations

The maturation process, an active and progressing development, runs its course to be most heightened in puberty and then gradually to merge into adult life. Masturbation which was regularly practiced in puberty gives place to normal sexual life. The ambitious narcissistic fantasies are replaced by full object love

Disturbances of this course of development may occur if prohibitions and castration threats are so severe or have such a strong effect, that masturbation is given up completely and the fantasies are completely repressed. These repressed fantasies may then lead their own life in the unconscious and, as mentioned above, may sometimes be cloaked in preoedipal forms. The instinctual life may regress. Instead of elaborating on the neuroses thus caused, I want to present two other fates of such repressed fantasies

a If a boy has developed a marked negative oedipus constellation based on a strongly bisexual constitution and in consequence of a specific

family constellation combined with specific experiences in early childhood, his castration anxiety will become exceedingly strong. For the gratification of these passive desires castration is a pre-condition, therefore they are a threat to his masculinity. They enhance anxiety and force repression of both fantasies and the masturbatory act. At the same time they sometimes paralyze activity in other areas and inhibit the maturation process of the entire personality. Escape back to a preoedipal fantasy world and the preservation of the passive father attachment of the negative oedipus complex support each other in an inhibitory effect.

b The other important factor, which in combination with the two just mentioned, may prevent normal maturation is evident in those boys who turn inwardly an extreme amount of aggression during superego development, the passivity involved in this mechanism is then secondarily erotized and is turned into masochism. We thus encounter beating fantasies which have been extensively described in all their various phases and forms by Freud (6). I will not elaborate on them but only mention that these fantasies always are of a sadomasochistic nature, i.e., the author of the fantasy always figures both as the beater and the beaten—while the act of beating is often replaced by fantasies of being overwhelmed, damaged, debased or castrated. The nucleus of these fantasies is always the fantasy of parental coitus, regardless of whether or not it has been observed in reality. In this fantasy the child in turn plays the role of the father and the mother and the content is tied to the preoedipal fantasies. These sadomasochistic fantasies may increase both the fear of and the struggle against masturbating. Masturbation will seem more evil, forbidden and dangerous than ever. I already mentioned in the beginning of this paper that it is of utmost importance to the adolescent whether the struggle against masturbation does or does not succeed. When it succeeds it produces an enhancement of self-estimation which in pathological cases may range from an abnormal increase of ambition to megalomania. If the struggle fails, feelings of inferiority, depression and pathological ideas of self-devaluation and self-abasement result. When these abnormal ideas of grandeur or of inferiority were chiefly the result of the threats of the adult world they are frequently accessible to simple psychotherapy. Reassurance and enlightenment may be miraculously effective and may undo inhibitions in the development of the entire personality. But if the disturbance has been caused by early inhibitions of development as a consequence of strong passivity, strong sadomasochistic tendencies and fantasies, preoedipal fixations and therefore defectively developed ego functions, the resolution of these developmental disturbances is very difficult and time-consuming and, if ever, only attainable by a correctly conducted psychoanalysis.

The difficulties are most intensive in the areas of maximum influence on ego development where consequently the disturbances of adjustment originated(3)

Let me select only a few from the many examples

1 A child who in his latency period completely gives up masturbation under duress of castration threats remains in a strong and mainly sadomasochistically tinged dependence on the adults. Whenever the urge to masturbate threatens he has to reinforce his submission toward the prohibiting persons. In adolescence this process repeats itself and the young man is incapable of becoming independent. He remains, as we term it, an infantile personality.

2 The complete suppression of masturbation due to external prohibitions may also lead to opposition against all adults. Being good in sexual matters is compensated by indiscriminate 'wanting everything different'. This type always and everywhere desires the opposite of the environment as it is. The objective evaluation of other people and situations is also greatly impaired in such cases.

3 The success in the struggle against masturbation by one's own power enhances the self-esteem, but it may lead to feelings of grandeur, which then stamp the entire personality. A lack of self-criticism, overbearing behavior, and overestimation of the self then result. These qualities go back to the early infantile feeling of omnipotence, and which disable the personality in adjusting to the real world.

4 If the struggle fails, self-accusations and self-torment and inferiority feelings ensue which may impair the development of all other qualities and talents and compulsive masturbation may paralyze all other activities of the individual.

5 Very frequently the struggle succeeds only partially with periodic break-throughs of masturbation. Then we find a vacillation between megalomaniac and inferiority fantasies, the one type always precipitating and increasing the other.

6 Most frequent are the mixed forms of all these types. All of them lead to adjustment disturbances. In cases with more marked inhibitory tendencies, ego deformations and ego constrictions result in addition to neuroses. In cases in which eruptions of instinctual impulses (primarily of aggression) lead to external acting out, we encounter delinquency.

Only by the thorough presentation of individual life histories could one do justice to the manifoldness and intricacy of the various combinations of possibilities, a goal beyond the scope of this paper.

So far, I have mainly presented the various vicissitudes of the masculine developmental process. Naturally most of these phenomena also are

found in the female. However, I want to draw attention to some particularities in the female development.

I mentioned above that the complete suppression of masturbation during latency and perhaps during puberty also, is a much more frequent occurrence with girls than with boys. This is the case even when the external prohibitions and the threats of punishment were the same for both sexes. The normal oedipus situation demands of the girl the renunciation of active phallic desires, of the boy the renunciation of his passive strivings. It appears that with an equally strong bisexual constitution the subordination of passivity to activity is more easily effected than the reversed process. Instinctual life has an essentially active driving urging quality. Moreover the danger of castration, which once had seemed to the boy overwhelmingly great, is and remains only an anxious fantasy which never becomes reality. If the passive constitution and with it the desire for castration is not too strong, the conquering of the castration anxiety is effected without too great a difficulty.

The girl, however, is convinced without redress by her observation of the sex difference, that she will never obtain the once ardently desired male genital even though for a long time she still retains the fantasy that it will grow in her. This narcissistic injury is a decisive factor in taking the pleasure out of masturbation, and in renouncing it.

With normal feminine constitution these two processes turning to passivity and the acceptance of the lack of a penis, are successfully accomplished either during latency or puberty. The active strivings are sublimated and employed for other ego functions as well as for intellectual development. However, this process remains more difficult than the analogous one in the boy.

The girl's passive situation in the oedipal father relationship seems to favor the renunciation of masturbation. At least one can observe that it is the girl with a strongly bisexual constitution who fails in the masturbation struggle. At first glance this appears strange since it is the girl with strong active desires whom one might expect to be most injured and disappointed by her lack of a penis. One would expect her to withdraw from the manipulation of her defective genital at the earliest time. The explanation for the contrary fact is given by the fantasy world of these little girls. In the fantasy the lack of the male genital is regularly denied: it is hidden in the vagina and one day it will come out or it will grow. The heroes of her daydreams or unconscious fantasies are frequently boys or young men and are easily recognizable as the ideal image of herself. Or the little girl repeats her fantasies of the parental sexual life (in various alterations of course) whereby she simultaneously plays both roles, the active and the passive. Also there is often a fantasy of being

father's penis or the penis of the phallic mother. Geleerd describes a case in which compulsive masturbation, which gravely inhibited the little girl's development, was accompanied by many such fantasies(9).

Frequently also manipulation of the genitals, whether clitoris or introitus, is given up and displaced onto other parts of the body. (Playing with the nose, mouth, ears, hair, breasts, rubbing of the legs, etc.)

A further particularity of the fantasies of the constitutionally active girl is that they are sadomasochistically tinged. In "A Child Is Being Beaten," Freud points to the fact that beating fantasies occur more frequently with women than with men(6). The passive "letting oneself be beaten" (letting oneself be overpowered) is, according to some authors, part of femininity. However, in normal femininity it plays a role only to the extent of a capacity for physical submission. If there exist strong sadomasochistic elements we are already dealing with a deformation of healthy femininity which is the consequence of a marked active-aggressive constitution. Aggression is partly turned inwardly; but also where masochism is apparent psychoanalysis uniformly reveals strongly sadistic fantasies. These fantasies substitute for the renounced masculinity and simultaneously take revenge on the envied male or on the mother-woman who is held responsible for the patient's sex.

Thus the active type of girl like the boy does not succeed easily in renouncing masturbation. Where the environment has enforced its prohibitions, the reactions and character formations are also similar; yet if the suppression of masturbation is forced by severe threats of punishment the girl, too, may develop into the type of the "constant rebel" or she may remain the dependent child who cannot grow up.

Suppression of masturbation by her own efforts may also produce megalomaniac ideas and overbearing behavior in the girl whereas feelings of inferiority may be awakened by the temporary failure in this struggle.

For the development of sound femininity the gradual renunciation or reduction of masturbation during latency, at least in our present civilization, seems to be most favorable. A mild relapse during puberty with preference of introitus or vagina may serve the transition to adulthood. However, in many cases there is little or no masturbation at all in puberty. This may be an escape from the above-mentioned fantasies, originating in the masculinity complex, or it may also be caused by guilt feelings and anxiety and thus have a neurotic basis. But it may also be a preparation for the healthy submission to adult sexual life during which normal vaginal orgasm is experienced for the first time and the remainders of the infantile fantasies are adjusted to adulthood and thus enter the realistic world of the woman, in family life, and in other social or professional tasks.

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STRUCTURAL ASPECTS OF A CASE OF SCHIZOPHRENIA

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INTRODUCTION

The study of the case of H is the first publication of a number of investigations of schizophrenia, in all of which I arrive at the conclusion that schizophrenia is not preceded by an infantile psychotic state that in this respect a psychosis differs radically from a neurosis, for which there is always an infantile basis

In almost all cases of schizophrenia a distinction can be made between a prepsychotic period and the psychosis proper. The study of the relationship between the prepsychotic and the psychotic symptoms enables us to gain insight into the structure of the delusion and its related phenomena

Many times the beginning of the prepsychotic phase is marked sharply, as when symptoms appear which show that important parts of the personality have disappeared. Notwithstanding this disappearance, contact with reality is still maintained. The prepsychotic period is characterized not only by dropping out phenomena but also by mechanisms that try to ward off the danger of losing contact with reality. Sometimes even attempts at recovery are made by remnants of the personality

There are other cases of schizophrenia where the beginning of the prepsychotic period is less sharply marked and where symptoms seem to develop as an exacerbation of a situation already long in existence. In these cases it is not certain whether these exacerbations differ only quantitatively from the preceding state or whether a qualitative change has also taken place

In addition there are a number of borderline cases which show symptoms of a prepsychotic nature but which never develop into a real psychosis. For the patients still succeed in maintaining contact with reality. We know that puberty now and then takes a course which strongly resembles prepsychotic development. Fortunately, however, such puberal development frequently takes a turn for the better

The psychosis proper starts when contact with reality has been abandoned. The delusion and almost all of the other schizophrenic symp-

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toms are to be conceived of as an attempt at restitution—an attempt which, of course, differs completely from the eventual attempt at recovery made during the prepsychotic period. The prepsychotic attempt tries to restore connections with objective reality. The delusional attempt, on the other hand, creates a new subjective reality and, instead of restoring connections with objective reality, leads further away from it.

According to my experience, the delusional attempt at restitution never occurs before the end of the latency period

My conception of schizophrenia differs from that of many child therapists from both a diagnostic and a structural standpoint. It is for this reason that this article is published in *The Psychoanalytic Study of the Child*, as an illustration of the beginning of a psychotic development in puberty.

CASE OF H.²

When I first saw the patient, he was twenty five years old and was suffering from a psychosis which had started eight years prior to that time

H was an only child. Until his fourteenth year his development appeared to be normal. He attended the Christian H B S³ and was considered to be among the good pupils. At this school he was greatly influenced by a friend who told him about the pleasures of onanism. Yielding to this practice, H masturbated about three times a day. His first onanistic fantasies concerned a woman with a penis; later, he fantasied about performing interfemorary coitus with a woman. The objects of his fantasies were almost always suggested by his friend's remarks. For instance, if the friend said, "There is a pretty girl," the patient would masturbate, fantasizing about this girl. During this period of onanism, his school work became progressively worse and he had to repeat the third year.

This period of onanism, which lasted about one year, came to an abrupt conclusion. One day his friend asked him whether he was still masturbating, and then continued, "Don't you know that that makes you crazy?" Immediately H broke off his onanism.

Now a new phase commenced. Exerting all his willpower, H succeeded in suppressing masturbation. He thus was better able to concentrate on his work and obtain better grades. As a result he was promoted to the fourth year. This period of better concentration is characterized by a series of self-limitations which he himself called "self-conquests." He was always aware that these actions seemed ridiculous and exaggerated. The following will help to acquaint us with the motives of these actions.

2 I owe the greatest thanks to the late Dr. Oort, who offered me the opportunity of studying this interesting patient. I examined H during 1929. Since then my concept of this case has grown gradually. I published this case in 1946 as a chapter of my thesis "De Grondbeginselen van de Waanvorming" (The Basic Principles of the Formation of Delusions). The English publication of this case differs considerably both in its representation and in its concept from the Dutch one.

3 A type of Dutch school combining high school and junior college.

His friend had a girl with whom our patient also fell in love. But instead of competing with his friend as one would expect he tried to win the girl by imitating him. To achieve this similarity he began to impose various self limitations. His friend was not allowed to go out evenings though H was not forbidden this freedom. He therefore did not go out. His friend was often punished therefore our patient punished himself in various ways one of which was squatting in the cellar in a deep knee bend for one hour a position which he found very uncomfortable. He did various foolish things such as entering a street car with his brief case on his head putting his gloves on inside out asking his teacher whether there was chocolate on his mouth when he had not eaten any. Despite his reluctance to make himself ridiculous these deliberate self humiliations were designed to equal the humiliations which he felt his friend was undergoing. He also frequently asked his father for forgiveness on a number of occasions although he knew that he had done nothing wrong.

After he had advanced to the fourth year his self conquests stopped suddenly and characteristically. He felt he had changed enough so that his resemblance to his friend had removed any reason why the girl should not substitute him as her boy friend. But at this same moment he performed his last self conquest. He decided to abandon the girl. He subsequently explained to me that the original means had by then become the goal.

H now ceased all his efforts. He was unable to keep up his school work and left the school. He took a minor examination for the post service and passed successfully but did not seek employment. The situation became deplorable. Still he persisted in warding off masturbation.

After his decision to abandon the girl the patient's will power was no longer concentrated on self conquests but in their place there now appeared an extensive ceremony of washing and dressing. The patient would lie in bed until eleven o'clock in the morning and then would take until six o'clock in the evening to finish dressing. At his parents request he was admitted to a sanitarium where he remained for half a year. The night before he went to the sanitarium he did not go to bed at all fearing he would miss the train the next morning.

Changes came about gradually. H began suffering from the idea that his father influenced him so that he was no longer master of his own thoughts. In his twentieth year delusions of grandeur were added to his other symptoms. He thought he was the Count of Hooren. This name differed only in a few letters from his own family name.

The patient's delusional ideas became more extensive. He also began masturbating again after a doctor had told him that this practice did not have the harmful effects ascribed to it by his friend. Very soon he was masturbating five or six times a day. His ideas of persecution became centered around his father whom he accused of homosexuality. H felt threatened by his father because of the father's presumed need to satisfy his homosexual goals. H felt that his father wanted to castrate him to devour him to poison him etc. His fear of his father increased. When the father once picked up the kitchen knife

to cut some meat, H. ran away from the house and sought protection at the home of an aunt. When he was admitted to the sanitarium for the second time, he said that he never wanted to return to his father's home again.

His delusions of grandeur were concerned with the future. For instance, he believed that if certain conditions took place in the future, he would become King of France, Count of Hooren, Maximilian d'Autriche, and Prince of Hombourg. His mind seized on the historical circumstance that Louis XVI had been beheaded during the French Revolution and this son apprenticed to a shoemaker. Since no one had ever been able to discover any trace of his son, the patient reasoned that he himself was this descendant and that as soon as he received his "maja" in visible form, he would become King of France, etc. This idea of his "maja," together with his theories of the "Realm of the Dead" had many features so that it will be necessary to give these two concepts in some detail.

The patient sometimes called his "maja" his astral body. He conceived of it as something he had once possessed but had subsequently lost at the age of four, when, according to his delusion, his father had threatened to castrate him with a knife. Therefore, his mortal fear of castration forced him to relinquish his "maja." Thus his wish to regain his "maja" is quite understandable. He also called his "maja" the shadow of his soul, and since shadows are dark, this quality served to connect his "maja" with the "Realm of the Dead" where darkness reigned—the same darkness, as he said, as that which exists at the point where the leaf of a plant emerges from its sheath. H. further conceived of his "maja" as bewitching the senses. He would have various bodily sensations such as pressure on his head as though there were a ring around it. This ring also passed over his eyes and made him think of the crevice of the "Realm of the Dead," simultaneously awakening the thought of the precipitation of his "maja," i.e., the regaining of his "maja" in visible form.

Though his concepts of "maja" and the "Realm of the Dead" are connected, they are not identical. The realm of the dead was the domain of homosexuals but he never connected "maja" with homosexuality. According to H. since homosexuals do not have children—i.e., are not succeeded by anything living—they look with favor on the "Realm of the Dead." His ideas of persecution by his father are connected with this concept of the "Realm of the Dead" as follows. He believed that his father wished to devour him. H. had always equated devouring, annihilation and castration. In his conversation, numerous oral-erotic expressions occurred. Cannibals ate brave people, he said, in order to be brave themselves. He said also that eating was done out of love, citing as an example the remark sometimes made to small children, "Come here and I will eat you up." H. claimed that when he was three years old, his father had devoured him "astrally"; in other words, his father had eaten him alive, as people called it. H. therefore believed that he himself had lived in the "Realm of the Dead" for a short period at that early age. He thought of his father's body as surrounding him astrally in the form of a ring (i.e., a vagina) around his penis.

The Realm of the Dead as pictured by our patient contained the astral bodies of the dead and could be reached through the mourning curtains of Notre Dame de Paris where the Sacré Coeur is kept. Another name he gave to the Sacré Coeur was *utérus* (accented on the *e* according to his pronunciation).

His reaction to homosexuality was violent and much elaborated. Not only did he accuse his father of being a homosexual but he also saw both the French Revolution and the Christian religion as being very intimately connected with homosexuality and thus with the Realm of the Dead.

The cause of the French Revolution as H saw it was the insurrection against homosexuality. The knights went hunting and stamped down the peasants' grain. This destruction of the seed was to H equivalent to the homosexual act since homosexuals did not wish to produce anything living and therefore would not allow the seed to mature. According to H's interpretation the peasants in revolting against the knights were putting up resistance against homosexuality and therefore homosexuality could be considered the main cause of the French Revolution.

Although H had attended the Christian HBS he turned out to be an enemy of all religion. He argued that religion sprang from man's fear of death that man for his protection created gods whereas actually according to H no help could be received from gods because they did not exist. H was particularly opposed to Christianity considering Jesus Christ a homosexual. Jesus voluntarily had chosen death and was thus in favor of the Realm of the Dead.

Killing to H was also an expression of homosexuality for in this way the murderer showed his favor for the Realm of the Dead. Cain slew Abel. Was Cain a homosexual? H asked.

Now and then H would express his ideas on masturbation in ways characteristic of boys in their puberty. He would tell with pride how many times he had masturbated in his life and calculate the volume of semen he had produced. But he complained that in spite of having masturbated many times a day he could not do so without having first to win an internal battle. He believed that he would be cured when he could masturbate without resistance whenever he felt the desire. He expected this change to occur when his *maja* returned to him.

Although in time the elaborate dressing ceremonial more or less disappeared still the patient would never sit down without first carefully wiping his chair. He was particularly careful about his pants, fearing that they might be torn and that he would have to go about wearing patches.

At this time both the patient's appearance and mannerisms attracted attention. He had a long blond beard which was in striking contrast to his still youthful face. His peculiarities showed themselves in his queer walk, in his strict dress and in the heavy cane which he always carried on his walks. He was very fond of talking although he was somewhat uncommunicative about the early stages preceding his psychosis.

THE PREPSYCHOTIC PHASE

A survey of his symptoms shows us that there was a detectable period of change before his psychosis developed. This period of change, which I will call *the prepsychotic phase*, covers the time when his symptoms neither belong to the ordinary neurosis (hysteria, compulsion neurosis, etc.) nor are they psychotic in character. There were three stages of marked change during this prepsychotic phase—namely, the masturbatory period, the period of self-conquests, and the period of the dressing ceremonial.

The loss of contact with reality which was unmistakably clear during the third period was already present, although to a minor degree in the first. The patient's efforts at self-conquest, during the second period, succeeded for a few months in interrupting this process of personality decay and even led to an improvement at school. But once the efforts were exhausted his personality disorders became increasingly apparent.

After this reconnaissance of the prepsychotic phase, let us consider each period in more detail.

A. THE MASTURBATION PERIOD

This period began with the puberty stage, in which symptoms very often adopt a disquieting character without necessarily serious consequences. H's friend represented an ideal to him, and he therefore followed in his friend's footsteps as much as possible. Under his friend's influence, H began to masturbate, and the choice of his onanistic fantasies was determined solely by his friend's choice remarks, without any further instigation from his friend.

Such a development is not rare in puberty, and from these symptoms alone one could not predict the subsequent outbreak of the psychosis. Even the decreasing interest in school work does not point in that direction. However our survey of the prepsychotic phase makes it clear that H was developing in such a way as to be headed for disaster.

In the beginning H's masturbation was accompanied by fantasies of girls with a penis. From experience we know this symptom to be evidence that the vagina had aroused our patient's castration fear and that he tried to ward off this fear by providing the girl with a penis. Later, however, he dropped this idea from his fantasies. If we assumed from this that he had acquainted himself with the existence of the vagina and that his anxiety had been lessened, we would be assuming a growth toward normality. But since H's personality was beginning to decay, we can make no such assumption and for the time being cannot be sure why, in his masturbatory fantasies, H discarded the idea of the woman with the penis. This

fact does not give us insight into the causes of H's change of personality. To find these we must look for other evidence.

At this point let us recall the event which put a stop to the patient's masturbation. His friend's remark that masturbation would drive him insane brought about this change. It is obvious that the threat of insanity meant a threat of castration to H. This interpretation is corroborated also by the fact that the patient often referred to the subsequent period of his self conquests as a defense against castration.

To understand the meaning of the masturbation period we must discover the cause of the castration fear. Although his friend's remark that castration leads to insanity shocked him, it obviously was not responsible for that fear. It only threw a light on the desperate situation in which he already found himself at that time. The content of his onanistic fantasies was derived from his friend's casual sexual remarks about any girl who then immediately became the center of his masturbatory fantasies.

H's relation to his friend, as will become clear presently, was of a homosexual nature. The manifest heterosexual fantasies must not confuse us. They served merely to disguise strong unconscious homosexual desires. For we see that in the following period of self-conquests he used his love for his friend's girl as one of the means of overcoming masturbation. If H's castration fear had been based on well founded heterosexual drives, he would not have used a state of being in love with a girl to overcome this fear. The heterosexual content of his fantasies formed only a thin covering layer.

There is other evidence to show that H must have had strong homosexual feelings when engaging in his masturbatory acts. To support this statement I shall make use of some material from the period of self conquests.

One of H's self conquests was to ask his father's pardon although recognizing that he had done nothing wrong. H explained this by saying that he asked his father's pardon out of fear that his father would castrate him. He could not be persuaded to give more information. When I urged him to tell me more, he made the excuse that if he were again to think of this period of self conquests, his fear of castration and of death would reappear and he would again feel a soft sensation for his father and would place too much trust in him. This sensation of something soft around him he identified as being the "homosexual astral body" of his father, which would cover his own body. H said that if this sensation occurred, he would be forced to return to his father within three weeks, that since he had now escaped his father, he did not want to return to him.

I am not overlooking the fact that this statement by the patient is a

psychotic one. It was precipitated by my questions which awakened memories from his prepsychotic period. But apart from the delusional aspects of this remark it also clearly expresses his homosexual feelings for his father. It was these feelings which caused H. to fear castration and which he was therefore forced to ward off. From this and other material, we may conclude that the patient's relation to his friend was a displacement of his attachment to his father.

The fact that the patient reacted with anxiety to his unconscious homosexual drive makes it clear that this drive was of a passive feminine nature. Such a passive drive inevitably carries with it the wish to be castrated. The ego desires to maintain its integrity and so reacts to the unconscious feminine drive with fear.

Let us review once more the masturbation period. The influence of his friend is seen from the very beginning to have been based upon the patient's unconscious wish for femininity. H. started to masturbate upon his friend's advice. In these masturbatory acts he tried to satisfy not only his homosexual desires but also his heterosexual ones. We know that the thought of the vagina filled H. with fear, and undoubtedly this fear helped to weaken the heterosexual position. The switch from fantasies about girls with a penis to fantasies about girls as they are was only a superficial adjustment, due, I think, to the fact that his fantasies had to express the growing influence of his friend. As H., through his identification, adapted himself more and more to his friend's choices, his own conception of girls came to have for him correspondingly less importance.⁴

This strong, unconscious feminine attachment to his friend, which caused him to be continually sexually aroused by him, made any passing remark by his friend about a girl a stimulus for the desire to masturbate. He never imagined himself in the passive homosexual role with his friend. Instead he warded off such direct homosexual expression by disguising his feminine urges in identifying himself with his friend's masculine character. Thus the girl to whom his friend had drawn his attention became the center of his masturbation fantasies.

The mental processes revolving around the constant sexual excitement, caused by his homosexual attachment to his friend, deprived him of the energy which he needed for study. It was during this period that he was shocked out of this habit by his friend's remark that masturbation leads to insanity—which represented a castration threat to him.

4. After H. had become psychotic, he once visited a prostitute. According to him, prostitutes had no uterus. H. looked at the prostitute's outer genitals and asked where her vagina was. The girl thought that H. was trying to fool her. H. then left without having intercourse. It is clear that in the course of years H. had not increased his insight into female anatomy.

B THE PERIOD OF "SELF CONQUESTS"

In the second period, the problems revolving around masturbation were successfully warded off by the self conquests, and H temporarily established a better adjustment. We therefore may conceive of H's struggle as an attempt at reconstruction. This attempt resulted in a short period of success, but it evidenced many abnormalities.

Let us consider this period in some detail. H wanted to win his friend's girl and in order to do so, tried to be like him by means of what he called his "self-conquests." The last "self conquest," however, does not fit the description. Just when he was convinced that the difference between him and his friend had become negligible, he performed his last "self conquest" by abandoning the girl. The whole period, therefore, may be divided into one group of "self conquests" in which H endeavors to win the girl, and a last self conquest in which he strives for the opposite goal. Still, both contrasting directions are part of the same system. It should be recalled here that H often called the whole period of "self conquests" a defense against castration. This seeming insight into the motivations of his "self-conquests" is baffling. Ordinarily a neurotic is rarely able to give an exact description of his symptoms, much less can he be expected to have insight into his defense mechanisms. This insight is only gained by the process of analysis. Therefore this startling conscious awareness that H expressed about the motivations for his defenses must not be viewed as insight, but indicates an impairment of the ego even though there were also certain ego achievements during this period. His ego shows a crack through which the motivations of his defenses leaked into consciousness.

Let us now concentrate on the phenomena surrounding H's attempt to become similar to his friend whose girl he wanted to win.

This friend was not permitted much freedom. There were many things that he was forbidden to do, and on several occasions he had been punished by his father. Our patient's first "self-conquest" was his decision not to go out of the house on a certain evening because his friend had been forbidden to do so. On another occasion H inflicted pain on him self in imitation of the pain which his friend had experienced when punished by his father. In the same way he put himself in his friend's position by humiliating himself and playing the fool so that others would laugh at him, when he thought his friend had been humiliated by his father. The "self-conquests" in which H asked his father's pardon seem to be more complicated because they bear the personal mark of his re-

lationship to his father. As has already been discussed, H had to ask his father's pardon because he was afraid that otherwise his father would castrate him. But this type of 'self conquest' was also an imitation of his friend, who had misbehaved and therefore deserved punishment. It is apparent that all these self conquests had as their common denominator some form of self punishment designed to make H his friend's equal.

These self conquests were noteworthy not only because of their bizarre character but also because he did not identify with his friend's positive traits in order to gain the girl's love, instead, in his self-conquests he chose to identify with his friend's humiliation and suffering.

When the self conquests had lasted three or four months, H was promoted to a higher grade in school. At this time he thought he had changed enough to be exactly like his friend. He therefore thought that the girl might choose him instead of his friend. This thought, of course, had no realistic validity.

Most of H's self-conquests must have made a ridiculous impression on observers. No one would have guessed that he was trying to emulate his friend. At the same time this idea of similarity with his friend was not a delusion. He remained fully aware of the fact that he and his friend were two different individuals, although having certain traits in common. As yet we do not understand why H emphasized the fact that the girl should turn to him.

Hitherto I have referred to H's "self-conquests" as imitations. They were actions based upon the conscious motive of aping his friend. This conscious motivation, however, does not explain why he thought that these actions would change his ego so that he would closely resemble his friend. Therefore unconscious reactions also must have played a part in the development of this similarity. For this reason I have called this process an identification with his friend. H's imitations were conscious acts stemming from his unconscious desire for identification.

Let us now investigate the nature of H's love. When his love for his friend's girl was awakened, one would have expected him to enter into a competitive struggle with his rival. The facts, however, were quite the opposite. H's love did not show the slightest signs of being competitive. Moreover, there was nothing to indicate that a strong heterosexual drive supported his love. It is a known fact that certain bisexuals are able to love both man and woman, and with such persons it frequently happens that, if the homosexual urge no longer can be satisfied, the desire for heterosexuality predominates.

This process did not occur in our patient. Had a strong heterosexual drive been present, H would not have needed to build up an identifica-

tion with his friend through means of his "self-conquests" before he could express his heterosexual drives.

These many abnormalities in his love situation give us insight into H.'s peculiar attempts at restitution. Clearly the problem is to discover what means H. used to master his drive for femininity.

In the beginning of the "self-conquests" H. had no heterosexual drive strong enough to counteract effectively his desire for femininity. The identification with his friend served to create a basis for utilizing whatever heterosexual urge he still had.

This conclusion leads us to scrutinize the function of his identification process more closely. It then becomes apparent that the object of the identification is to resolve H.'s passive feminine relation with his friend; i.e., this relation must be transformed into an identification. The patient himself advanced this type of explanation for one of his "self-conquests": he asked his father's par' on in order to ward off his feminine feelings for him. It now becomes clear that this explanation is valid, not only for this particular "self-conquest," but for the whole group of "self-conquests." The task of the identification is to resolve the drive for femininity.

We now understand what the patient meant by his remark that the resemblance to his friend had, at a certain point, reached a sufficient degree. At this point his homosexuality either had disappeared completely or at least had lost so much of its strength that it might be considered negligible. His drive for femininity was now transformed into the identification with his friend. The road toward the girl apparently was no longer blocked. We find this idea expressed in H.'s statement that now the girl would have no reason for not substituting him as her boy friend. We have already stated that this idea was wholly unrealistic. It is also strange that at this point H. took no initiative but waited for the girl to act. We must examine more material before we can understand this peculiar fact. We would expect him at this point to show what heterosexual drive he had at his disposal. Yet instead, this is the moment when he performed his last "self-conquest" by abandoning the girl.

H. himself gave us the reason for this step by explicitly stating that the whole period of "self-conquests" was a defense against castration. Therefore by this last "self-conquest" of abandoning the girl he was warding off a heterosexual wish which would also lead to castration.

The danger of castration was the commanding factor during the period of the "self-conquests." The "self-conquests" had to resolve the drive for femininity because this drive carried with it the desire to lose the penis. This desire to lose the penis aroused anxiety in the ego, which

then fought the wish to be a woman. He mastered the danger arising from this unconscious wish by identifying with his friend only to be confronted with it anew by the castration dangers presented by heterosexuality⁵.

We have not yet sufficiently examined H's love for the girl. A successful love would have been an asset to his ego, for then the ego not only would have had at its disposal a safe defense against an eventual revival of feminine urges but also would have broadened its contact with reality. It is therefore not absurd to ask whether H's love for the girl was created in order to serve just this purpose. Moreover, in the preceding discussion we already have concluded that in the beginning of the "self-conquests" no strong heterosexual drive was present to act as a defense against the threatening desires for femininity. This conclusion, therefore, would support our suspicion that H was making an attempt to establish a heterosexual attachment for the girl.

We may advance another step and ask ourselves a new question. It seems as if H's love for his friend's girl fits into the frame of a triangular position. Was this situation derived from the oedipus complex? I must answer this question negatively by saying that the situation was only a counterfeit of an oedipus complex.

To prove this negative answer, let us assume, for the moment, that H's love for the girl was based upon an oedipal relationship. In that event, H would have been brought into a competitive position with his friend. However, we find no sign of such rivalry. The identification, for instance, did not resolve such supposed competition between H and his friend but, as we know, resolved merely H's homosexuality. Finally, in the oedipal situation, the identification with his friend would have oc-

5 There are also some indications that in the long run the identification would not protect H from castration. The warded-off castration would in time penetrate the defense. To prove this supposition we have only to look at the kind of traits which H borrowed from his friend in his effort to establish identification. This friend on several occasions had been punished not unjustifiably by his father. Through the identification the patient himself became the punished boy. He punished himself in order not to be punished later by his father. This interpretation is in full agreement with H's explanation of the "self-conquest" in which he asked his father's pardon in order to avoid being castrated by his father. The "self-conquests" therefore have the meaning of minor castrations which H inflicted upon himself in order to escape the greater damage which he otherwise would have had to suffer from his father. Such a process cannot go on indefinitely for then the defensive acts would become more and more saturated with the warded-off castration and in the end the punished boy would become identical with the castrated boy.

Because the "self-conquests" stopped with H's decision to abandon the girl, we may conclude that the castration was still excluded from the identification for if the castration had fully penetrated into the identification then the last "self-conquest" inevitably would have been the resolving of the patient's identification (a development which did not take place). The consideration set forth in this footnote is not vain philosophizing about possible outcomes but serves to clarify our insight into the structure of the prepsychotic ego.

companying his masturbation. In these fantasies he identified himself with his friend's masculine attitude.

These two processes, the drive toward femininity and the masculine identification, underwent quite different vicissitudes. Therefore let us now trace what happened to each in the succeeding period of self-conquests.

Here the identifications were accomplished by splitting his friend into two figures, one active, one passive.

The Passive Figure H's friend had been punished by his father. H conceived of this situation as the father forcing the son to accept a feminine role. In the period of self-conquests H identified himself with the feminine picture he had of his friend. Voluntarily H took this identification upon himself in order to escape castration from his father. This mechanism had been explained in the footnote on page 186. The purpose of this identification by means of the "self-conquests" was to rid himself of the drive towards femininity and the formation of this first identification was essential for the formation of the second one.

The Active Figure In the second identification H took upon himself the figure of his friend in love with a girl. This second figure, in contrast with the first, was an active one and had for him the meaning of a father image. His friend's masculine attitude as pictured during the masturbation period now becomes the core of the second identification.

It is interesting to notice that H did not completely rid himself of his feminine role. In his first identification he merely exchanged his own femininity for his conception of his friend's femininity.

We have now gained sufficient knowledge to be able to understand why H waited for the girl's decision to take him instead of his friend. We have seen that H never acquired a sufficiently active drive to make love to her. Through the combination of the two identifications, the feminine son and the masculine father, H now possessed his friend's likeness according to H's idea of it. Accordingly he was able to think that the girl could love him instead of his friend. The profound meaning of this thought was "If she loves my friend who is treated by his father as a girl, then she can also love me."⁷

⁷ Originally I had thought that the idea that the girl would choose H instead of his friend was a projection. When H had transformed his feminine urge into an identification I wrongly concluded that now he could shift his love from his friend to his friend's girl. This shift then would be changed by projection into the idea that the girl might transfer her love from H's friend to H. Such a projection would have concealed H's original love for his friend.

The error I made was in thinking that it was possible for H to shift his love in this way. The fact remains that H was incapable of forming the active drive needed to effect such a change. Accordingly I had to drop the idea of a projection. Clearly all that H could hope to obtain through the identification was the fulfillment of a passive goal, namely to attract the girl's love.

During the period of self conquests the general tendency towards decline of the personality was interrupted by an improvement in H's situation. From this clinical fact, discussed in the beginning, we were able to decide that an attempt at recovery was at work during this second period. Hitherto we have discussed only the defense aspect of H's reactions, which caused the feminine drive to disappear by transforming it into an identification. The sexual excitement resulting in masturbation was caused by this feminine drive, and with the transformation of this drive, the excitement disappeared.

In any attempt at restitution we must look for more than merely a defense. We may expect to find in such an attempt the tendency to recover what has already been lost, on the assumption that the energy which otherwise would have been expended in the excitement and its related processes will try to repair the damage. But this explanation deals only with the economic aspect. For the purpose of our metapsychological insight we need to understand the psychological and the dynamic aspects as well.

A discussion of the two types of identification will help us to broaden that insight. In both identifications we find the common element of H's imitating certain attributes of his friend.

Let us consider first H's identification with the active figure because this identification promises a quick approach to our goal. Here the patient became identified with that part of his friend which was in love with the girl. Through this identification H tried to restore an oedipal bond which already had been lost. This type of identification is certainly an instructive example of an attempt at restitution. The advantages of the re-establishment of the oedipal bond have already been mentioned.

Next it is necessary to investigate whether the imitative factor in the 'self conquests' may be regarded not only as a defense but also as an attempt at reconstruction.

At this point perhaps someone will suggest that the punishments which H inflicted upon himself were the result of unconscious guilt feelings arising from his superego. However, there is no evidence of the overwhelming presence of this faculty. The ego did not feel compelled by feelings of guilt to perform the self conquests. Rather, the ego acted on its own behalf. Although it found those actions foolish, it had no other means of escaping the threat of castration. Furthermore, we are impressed by the fact that what appeared to be H's feelings of guilt were mere imitations of his friend's guilt.

Normally, the superego is a faculty which guides the individual through life and contributes in a marked degree to making him as independent as possible in his judgment and behavior. Our patient did not

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possess this faculty Through the identification with his punished friend he gave the impression of having a superego Yet his superego was only a pseudo one, an imitation of certain attributes of his friend We may consider this reaction a part of his attempt at restitution, just as the pretended love also served this purpose. His superego had broken down and by the creation of a pseudo superego he tried to restore this lack. For the time this pseudo superego was present, it freed H from his homosexual feelings and made possible improvement to the extent that he could be promoted to the next grade. Still, we must not attach great significance to this achievement, since H could attain it only by imitation

Helene Deutsch has discovered and beautifully described a new type of case in which there is a lack of object cathexis(1) Patients of this type compensate for their lack by an imitativeness which is based on an identification with their environment. By this means, not only certain bonds but also feelings of guilt are imitated(2) She calls these patients, by reason of their imitation of normal reactions, 'as if' patients

It is clear that the characteristics mentioned by Helene Deutsch can be applied to H's attempt at restitution during the period of his "self conquests" His case demonstrates clearly how the "as if" reaction was developed in a prepsychotic situation

H's development was normal until his fourteenth year Accordingly we may assume that until that time he possessed a not too disturbed oedipus complex, ego, and superego This structure was affected during puberty by the increase of sexual instincts Normally such increase leads to a strengthening of the oedipal demands, but this did not take place in H's case. As yet, our knowledge is too limited for us to understand why H's revived sexual instincts did cathect in an almost absolute manner the drive for femininity so that the positive oedipus complex died away The ego then lost the possibility of using the oedipus complex as a source for heterosexual attachment and was considerably weakened. The oedipus complex is also essential for the final formation of the superego, and with the catastrophic development in H's case, the structure of this important faculty was likewise affected.

The attempt at reconstruction brought relief. A pseudo superego and, in relation with this, a pseudo-oedipal bond were formed In normal development the fall of the oedipus complex is followed by the final establishment of the superego In H's attempt at reconstruction the pseudo superego was erected first, as though that faculty which was formed last were recovered first. We understand the reason for the occurrence of this sequence the pseudo superego had to eliminate the feminine drive with its inherent castration danger in order that the pseudo-oedipal attachment might take place. In H's case, before this

pseudo-oedipal attachment could be fully formed, it already had stranded on the castration danger. It is remarkable that the attempt at restitution was formed in the beginning as an escape from castration and that later this same danger caused the ending of this attempt.

Helene Deutsch mentions that from her study of schizophrenic patients she has the impression that the schizophrenic process passes through an 'as if' phase before it takes on the psychotic form (2, p. 319). The analysis of our patient confirms Helene Deutsch's impression. Still, it remains to be proved whether in every prepsychotic phase such an attempt at restitution takes place. We must postpone a definite judgment until the end of our study.

The fact that H. was still in his puberty was another reason for the development of an 'as if' reaction, in addition to the attempt at restitution during the prepsychotic phase. Anna Freud has described such reactions of a transitory character in puberty. She points out the tendency toward the breaking off of former relations, toward antagonism against the instincts, and toward the loss of contact with the outer world by falling back upon an ultimate narcissism. The patient "escapes this danger by convulsive efforts to make contact once more with external objects, even if it can only be by way of his narcissism—that is, through a series of identifications. According to this view, the passionate object relations of adolescents represent attempt at recovery" (3, p. 188). This attempt at recovery therefore must be conceived of as an intermediate stage. When the stress of puberty has become less intense, the ego then will be more powerful and will find a better means of adjustment of the instincts than escape into a narcissistic state.

The result in H.'s case was more serious: it was the definite breakdown of the attempt at restitution.

C THE PERIOD OF THE DRESSING CEREMONIAL

The attempt at restitution was an effort to restore those parts of H.'s personality that had already been lost. When this attempt was abandoned, the defects could no longer remain hidden and the decay of his personality became evident.

This new situation placed before the patient the almost impossible task of finding a new way of warding off the danger of masturbation. In the period of 'self conquests' the patient could not build up a masculine drive because the castration danger was too great. Neither could he accept his feminine drive, for this drive, too, would lead to castration. We are curious to know what happened to the feminine drive during the period of the dressing ceremonial, also, whether the attempt to build up

a masculine drive was completely abandoned or whether derivatives of this attempt still existed. However, we find no information to satisfy our curiosity.⁸

For a long period the time-consuming dressing ceremonial succeeded in its purpose of warding off masturbation. It seems that H spent almost his entire energy in this ceremonial.

It may be asked whether this state was already a hebephrenic one.⁹ It is true that H's interest in daily events more or less disappeared, but this loss of interest was to a great extent due to his ceremonial. Moreover, the lack of confusion in his speech and behavior contradicts a diagnosis of hebephrenia during this period. The continuing of his defense by his elaborate dressing ceremonial, which was not based upon delusions, is the deciding factor in drawing this conclusion.

For this reason I have considered the period of the dressing ceremonial as still belonging to the prepsychotic phase. With the appearance of actual delusions, the prepsychotic phase ended.

THE PSYCHOTIC PHASE

Let us begin our discussion of H's delusions with his particularly conspicuous delusions of persecution. These are all built according to the same pattern. H believed that his father had homosexual feelings toward him and that accordingly his father wanted to castrate him. This persecution H dated back to his early childhood, when his father, so H thought, had threatened to castrate him if he would not release his *maja*.¹⁰ To escape this danger, H had given up his *maja*. Another danger which H had to escape was the Realm of the Dead.

Political movements in the past as well as religious ideas were drawn into H's philosophy about homosexuality. An excellent example of schizophrenic thinking is H's conviction that homosexuality was the cause of the French Revolution. He rejected the Christian religion, considering Christ a homosexual because Christ had sacrificed himself.

⁸ See also footnote 13.

⁹ I raise this question because during this period H's case was diagnosed by a psychiatrist as hebephrenia. Such errors are made repeatedly because the reason why a patient has lost his interest is not considered. A diagnosis of hebephrenia should not be made in those cases where the loss of interest results from a mechanism through which the ego tries to ward off an unconscious urge. In hebephrenia the loss of interest is due to a loss of ego cathexis as well as of id cathexis. This difference not only is the result of theoretical considerations but also is expressed through clinical phenomena. In the first group of cases the patient always complains in one way or another about his loss of interest. The hebephrenic patient however is not aware of his loss of interest. For even if so he is not concerned about it. We may conclude from the whole behavior of the hebephrenic, that he is in a state of complete apathy. If he is asked how he feels he will say "fine" or will make a noncommittal reply. Generally a discussion will "peter out."

H's notion of persecutions in the past provides a basis for the idea of redemption in the future. It was in the past that he had lost his "maja" and it will be in the future that his maja will return to him. The return of his "maja" will be the sign that he has become King of France, Count of Hooeren, Maximilian d'Autriche and Prince of Hombourg. Equally important, he will be rid of his persecutions. Furthermore his masturbation will have changed its character, he will be able to masturbate at once when the impulse arises, without first having to overcome his resistance.

We now see that H's delusions may be divided into two groups.

(1) *The first group of delusions are related to the present.* In this group belong the persecutory delusions. H's father, to satisfy his homosexual wishes, wants to castrate H. This persecution, according to the patient, already had begun when he was in his early childhood. The delusions of this group are accompanied by masturbatory acts. However, before the patient can engage in these acts, he first must overcome an inner resistance.

(2) *The second group of delusions are related to the future, at which time H expects his 'maja' to return to him.* He then will be in a state of undisturbed megalomania when the persecutions will have stopped and he will be able to yield to the masturbatory impulse at once without first having to overcome an inner resistance.

We start our investigation of H's delusions *perforce* by an analysis of their content since we have as yet no knowledge of their mechanism. We can hope, however, that this approach will gradually increase our insight into the problem of their mechanism.

Let us focus our attention on H's delusion about the loss of his 'maja'. According to H, he was then four years old. If we were dealing with a dream instead of a delusion we would immediately say that a childhood memory is involved. But since we still lack knowledge of the mechanism of a delusion, let us postpone the discussion of whether the content of a delusion may be analyzed in the same way as that of a dream.

The content of this particular delusion of H's leaves no doubt as to the nature of the event as H believed it to have taken place. H's statement, 'My father wanted to castrate me when I was four years old and I developed great anxiety,' may be interpreted to mean, 'When I was four years old, something happened which caused me to fear that my father would castrate me.' In order to escape this castration danger, H relinquished his 'maja'.

Our daily analytic experience is helpful to us in this connection. We know that in childhood the little boy is afraid of being castrated by his father on account of his love for his mother. Consequently the child represses his love, and his mother is lost to him as an erotically desired ob-

ject. By translating "maja" as "mother," we see that the content of this particular delusion may be transformed into an idea with which we already are familiar.¹⁰ It is quite common for a child of four to struggle with the problem of the oedipus complex. Only, the end of the oedipus complex at the age of four is abnormally early.

We also must remember that this particular delusion of H's belongs to the persecutory group. The father, according to H, had homosexual intentions and therefore wanted to castrate H. The threat of castration, as well as the homosexual intentions of his father, may be conceived of as a projection of H's own wish to be castrated because of his feminine feelings toward his father.

From this discussion, it follows that the event which H regarded as a castration threat *had its effect on two bonds which were present simultaneously*—on the oedipal attachment to his mother and on a feminine attachment to his father. After the traumatic effect of the castration threat, H relinquished the attachment to his mother but retained the homosexual attachment to his father. The survival of the homosexual bond is proved by H's statement that from the time of this childhood event until the present his father had persecuted him with homosexual intentions. Although he had lost the oedipal bond, he believed, however, that he would regain it in the future when his *maja*, i.e., his mother, would return to him. The return of his mother would be the sign of his grandeur.

Here our curiosity is aroused concerning H's ideas of grandeur. Let us begin at once with the examination of his megalomania. H expects to become King of France, Count of Hooren, Maximilian d Autriche, and Prince of Hombourg.

We must keep in mind the fact that H does not expect to become merely some King of France, but the legitimate descendant of Louis XVI who was beheaded under the guillotine. This fact sheds light on the other delusions of grandeur, for almost all the other personages in these delusions underwent a fate similar to that of Louis XVI.

The Count of Hooren is a famous figure in Dutch history, who was decapitated in 1567 in Brussels by order of the Duke of Alba.

Maximilian d Autriche was the unfortunate Emperor of Mexico, executed in 1866.

The Prince of Hombourg, the principal character in Kleist's drama, commanded the army against the Swedes. Because he was in a dreamy

¹⁰ Objections against this interpretation that the loss to H of his *maja* meant the loss of the function of the penis are not valid. The fact that H masturbated constantly throughout the first period of the pre psychotic phase as well as later evidence which will be discussed further along in this article, confirms the interpretation of "maja" as meaning "mother."

state, owing to his love for a woman, the instructions he had received did not clearly penetrate his consciousness, and although he won the battle, he was court martialed and condemned to death for not obeying orders. At the last moment, however, his sentence was commuted. The mere threat of execution, however, is sufficient for H to conceive of the Prince of Hombourg as being similar to the other personages.

With the exception of the Prince of Hombourg all the personages in these delusions died an unnatural death. From H's statements we know that he considered being killed identical with being castrated.

We are now able to comprehend the content of the entire delusion. H's statement that 'as soon as he receives his 'maja' in visible form he will become King of France,' etc. means that with the return of his oedipal bond, his castration will be an accomplished fact.

Although we now have interpreted H's most important delusions, still another remains to be explained. This is the 'Realm of the Dead'. At first sight, the 'Realm of the Dead' seems to be rather confusing. Next, we realize that the idea of the 'Realm of the Dead' has a double meaning. On the one hand it appears to be a domain of homosexuality, on the other, it represents heterosexual concepts.

Let us consider first its homosexual meaning. A great many expressions revolve around the eating of human flesh. It is conspicuous that H in several instances used this concept as an introduction to identification. Cannibals ate brave men, he said, in order to become brave themselves. H also connected the eating of human flesh with expressions of love, as when he cited the remark sometimes made to a child: 'Come here and I will eat you up.'

His father, according to H, had devoured him astrally, i.e., had eaten him up alive. H therefore had been devoured by his father out of love and had reached the Realm of the Dead astrally. He had lived in the Realm of the Dead at the age of three. We may interpret this statement of H's to mean that at the age of three he already had castration fears related to his father. This fact proves that at that age H already had homosexual feelings.

Moreover, H conceived of his father's astral body as completely surrounding him. He thought of intercourse as consisting of a ring around his penis, i.e. the ring represented the vagina. Therefore H's body as a whole might be regarded as a penis surrounded by his father's astral body in the form of a vagina.

The anamnesis brings to light the fact that devouring and annihilation are identical with castration. We now see also that H conceived of being devoured by his father as a homosexual coitus, i.e., a coitus which had also a castrating effect. This concept agrees with his concepts that his

body as a whole had become a penis. Genitalizations of the body are always a result of the disturbed function of the genital itself.

Not only is the active devouring or annihilation of some object a homosexual expression of love, but also the passive surrender to being devoured by another is homosexual. This homosexual pattern recurs in many of H's ideas. For instance, he asked whether Cain was a homosexual because Cain slew Abel. He also made Christ's voluntary surrender to crucifixion the reason for calling Christ a homosexual. Christ further more, according to H, was devoured at the Holy Supper.

The foregoing, I believe, sheds enough light on the homosexual side of the 'Realm of the Dead'. We also have established that the dominating factor in all of H's ideas is the castration threat which proceeds from homosexuality.

Let us turn now to a discussion of the heterosexual meaning of the 'Realm of the Dead'. The 'Realm of the Dead' is related to the darkness which reigns at the place where the leaf of a plant comes out of the sheath, which is the symbol of the vagina. We already have concluded from H's fantasies about girls with a penis that H had strong anxiety concerning the vagina. This fact was also made clear by his visit to a prostitute.

The 'Realm of the Dead' contains the astral bodies of the dead and can be reached through the mourning curtains of the Notre Dame de Paris; one then comes to the *Sacré Coeur*, which is the womb. The symbolic representation of the mother by Notre Dame, with the womb innermost, leaves nothing to be desired in the way of clarity. The astral bodies of the dead mean castrated men who are now back in utero.

The thoughts which H connected with the sensations in his head also contain symbols which are not hard to explain. H conceives of a ring around his head, which also passes in front of his eyes and reminds him of the entrance to the 'Realm of the Dead'. This ring arouses thoughts of the precipitation of his "maja" which now takes on visible forms. H himself explained the ring as symbolizing the entrance to the "Realm of the Dead," and this entrance is, in turn, a vaginal symbol.

In the symbolization of coitus with the mother, H's whole body again becomes the penis and in passing through the vagina an act in which the eyes play a role, very probably fantasies of birth and of an intra uterine return are worked out.¹¹ From this conclusion, and particularly from the description of Notre Dame, it becomes clear that by a return to the mother is meant a return to the womb.

One more question remains concerning the "Realm of the Dead",

¹¹ Our examination of the heterosexual side of the "Realm of the Dead" thus supports the conclusions that "maja" equals "mother".

namely, what is the connecting link between the homosexual and the heterosexual aspects of the Realm of the Dead? If this link were not present, the all inclusive concept of the Realm of the Dead probably would not have been formed. The answer should cause us no difficulty. We already know that both the heterosexual and the homosexual or feminine urges may be regarded as leading to castration. The Realm of the Dead therefore becomes synonymous with castration. For this reason H struggled hard to keep out of it (See paragraph (2) below).

It now remains for us to evaluate the results obtained from our interpretations. Three problems appear in the foreground: (1) the loss of the oedipal attachment at the age of four; (2) the role of castration; and (3) the idea of uninhibited masturbation at a period some time in the future. The second and third problems appear to be closely related.

(1) *Our interpretation of the patient's delusion about his childhood* reveals that the oedipal bond was lost before it was fully developed. Under the influence of a castration threat, H abandoned the oedipal bond in favor of an urge for femininity.

Our investigation of the prepsychotic phase has shown the lack of an oedipal bond strong enough to fight the dangerous passive feminine urge. This finding fits in with our conclusion about the event which occurred when H was four years old. The loss of his oedipal attachment at that age in favor of his homosexual drive is so important a factor in the later development of his psychosis that we shall return repeatedly to this striking event. In this connection we shall want to discuss also the difference between the process as it took place in the development of our patient and the passing of the oedipus complex as it occurs normally.

(2) H's ideas about castration pose for us even more intricate problems. H avoided the Realm of the Dead because he thought of that realm as being a place of castration. Still in his future megalomania he accepted the idea of castration. Although we perhaps cannot quite grasp this concept we are led to conclude that for H there were two different types of castration. The first one represented an extreme danger in that it led to the Realm of the Dead. Of the other type of castration H highly approved for he believed that it would cover him with grandeur.

(3) H's thoughts concerning masturbation pose for us similar problems. During the period that I observed H he masturbated frequently. Every time he did so however he had to overcome an inner resistance. Yet he believed that in the future when his grandeur was established he would be able to masturbate at once without being inhibited. This future masturbation inasmuch as it necessarily will be performed without a penis

is therefore quite different from the actual masturbation. This concept of future masturbation remains somewhat obscure to us. Still, we may assume that at the time of this future masturbation, when H will have accepted castration, he need not have any fear from this source.

This concept of future masturbation offers an illuminating solution of the problem of H's resistance against his actual masturbation. This type of masturbation revolves around his penis, and H's resistance undoubtedly is caused by his fear of castration.

If this assumption is true, we may conclude that two types of masturbation figure in H's psychosis. The actual masturbation is centered around his penis, and before our patient can perform this act, he must overcome his fear of castration. This fear stems from his horror of the 'Realm of the Dead,' a domain synonymous with castration as related to incestuous homosexual and heterosexual wishes. During H's psychosis his masturbatory fantasies did not contain any conscious incestuous ideas. At the time of his future grandeur, the lack of a penis as an executive organ would mean that H could perform his masturbatory acts uninhibited by any resistance. This conclusion, supported by corroborating evidence in the case of Schreber(8), points to the presumption that the patient will be able to accept castration as soon as he can prevent his sexual excitement from causing penis reactions.

We now have reached the point where we can extend the field of our investigation so as to be able to scrutinize the process of delusion formation more closely. To do this, let us compare the first two periods of the prepsychotic phase with the two groups of delusions. At once we are impressed by the correspondence between (A) the masturbatory period and the delusions of persecution, and also between (B) the prepsychotic period of self conquests and the ideas of grandeur.

A. In the masturbatory period an unconscious feminine attachment to H's friend caused the masturbatory excitement. H's ego repressed his desire in order to free himself from the fear of castration. In H's persecutory delusions the same conflict is present and laid wide open. H believed that his father wanted to castrate him in order to make a girl of him and thus to be able to abuse him sexually. *What was originally an unconscious wish on H's part becomes, by projection, his father's wish.*

Both the prepsychotic and the psychotic periods were accompanied by intensive masturbation. The prepsychotic period started when H's friend advised H to masturbate. Similarly, in the psychotic period a psychiatrist told H that masturbation was not dangerous whereupon H returned to the practice. During these masturbatory acts H avoided thoughts which would lead him to the 'Realm of the Dead.' Similarly,

in the prepsychotic masturbatory period he stayed away from homosexual fantasies¹²

B The comparison between H's prepsychotic attempt at recovery and his delusions of grandeur is even more interesting than the preceding comparison

A point was reached in the prepsychotic attempt at restitution when H's homosexuality was bound up in his identification with his friend and he consequently was convinced that the girl (his mother imago) could take him instead of his friend. At this point however, H performed his last self conquest by abandoning the girl, for he could not overcome his fear of castration.

The future, as H envisions it, will bring the return of his *maja*' (mother). This return of his *maja* will be the sign of his grandeur. In his megalomania he will identify himself with executed (castrated) father imagos. No persecutions will take place. Moreover, he will be able to masturbate as soon as the impulse appears.

We see that both periods have a common element in that the mother imago returns to the patient. The great difference is that castration is avoided in the prepsychotic state, whereas it is accepted in megalomania. The fact that masturbation is suppressed in the prepsychotic state, but is performed in the psychotic one, is of minor importance. As already discussed, H's masturbation in megalomania must take a different form.

Similarly, the return of the mother imago in the delusion shows the same weak trait as in the prepsychotic attempt at restitution. In the prepsychotic period there was only a planned imitation of his friend's attachment to a girl (an *as if* reaction). Upon arriving at the point where it remained to cathect this planned attachment, H had to stop. The whole plan stranded on the danger of castration.

Concerning the psychosis, it will be necessary to scrutinize the conditions that must be fulfilled in order to have H's mother return to him.

We have seen that in the prepsychosis H thought the girl could transfer her love to him when he no longer possessed a homosexual attachment to his friend. Accordingly in the corresponding psychotic phase, we must ask how H gets rid of the persecutions. For H's persecutory

12 It is possible that the doctor's advice concerning masturbation influenced the course of the psychosis to a considerable extent. Before he obtained this advice the patient believed himself already persecuted by his father. Therefore independently of this advice a correspondence already existed between the masturbatory period and the persecutory period. On the other hand the doctor's advice may have prolonged indefinitely the appearance of the persecutory delusions for we know that H would have to abandon the first type of masturbation at the time he accepted castration which time would mark the coming of his grandeur. If the patient had continued suppressing his masturbation indefinitely it is quite probable that he would have reached his state of grandeur much more quickly.

delusions represent his homosexual desires in projected form. It is obvious that when his persecutions are at an end, the time has come for the return of his "maja" (mother). Therefore, we must examine the means H used to get rid of his persecutions.

The danger of castration in the prepsychotic period forced H to bind his feminine urges. He accomplished this task through identifying himself with that part of his friend which was punished by the friend's father. That part of his friend H conceived of as his friend's "girlish" side. The corresponding psychotic period seems on the surface to be completely lacking in an analogous identification. Still let us see whether we cannot detect something which may be considered analogous.

It will be recalled that at the age of four, H's fear of castration made him relinquish his attachment to his mother and, because of the same threat, retain his feminine feelings towards his father. On this basis, a return to the attachment to his mother would indicate acceptance of castration. At the same time, in so far as his feminine feelings were concerned, acceptance of castration would mean a homosexual surrender (surrender to femininity), i.e., transformation into a girl. It thus becomes clear that acceptance of castration may be expressed in two ways: return of the mother to the patient, or transformation into a girl. With no oedipal attachment we might expect the persecution to end by H's acceptance of being transformed into a girl. However, he clung to his would-be masculinity and chose the other course. We may conceive of H's whole process in this way. As soon as he can prevent his penis from reacting, the danger that his father will castrate him will have disappeared. This point will be reached when he is able to suppress his penis reactions. The homosexual persecutions will then have come to an end, but at the cost of his acceptance of castration. This acceptance now makes it possible for his "maja" to return to him (= a return to the womb). At that time his megalomania will become active.

We are now in a position to discover why H made use of this infantile material in his delusions. This material paves the way for future developments. By stating how and when he lost his "maja" the patient already is anticipating its return, and at the same time he is able to cover the future with masculine grandeur. What the material still conceals at this point is the fact that the patient is striving for acceptance of castration.

Of necessity, our understanding must proceed slowly. However, we are now able to draw a few conclusions from our comparison of the prepsychotic and the psychotic periods. In the prepsychotic masturbatory period the danger of castration arises from H's unconscious wish to be a girl. In the corresponding persecutory delusions the same danger arises

from the outer world Through projection, the inner danger has become an outer one This transfer, at least, may be considered an advantage

It is much more difficult to see the advantage to be gained from megalomania In the prepsychotic period of self conquests the patient, after having mastered the homosexual urge, had to abandon the attempt because he could not conquer the castration danger related to his love of his friend's girl In the psychosis his megalomania will be established as soon as he accepts castration, by this means he will get rid of the homosexual persecution

There is another consideration As already discussed, there are two types of castration (1) a dangerous type, represented by the "Realm of the Dead," which is to be avoided, and (2) a desirable type, in which H will be covered with grandeur Also, we have concluded that in megalomania H's masturbation will be performed in a different way Therefore in megalomania H will have rid himself of persecution, of the undesirable type of castration, and of the old form of masturbation

We may decide that H, in his psychosis, returned to the same pattern which was already present in the prepsychotic state In the masturbatory period he fought his urge for femininity In the persecutory ideas he fought this same urge Again in the prepsychotic attempt at restitution he tried to get rid of his homosexual tendency and, upon succeeding at tempted to build a fence around it so as to shut it out forever, in this attempt he failed because he was unable to form an oedipal bond In the psychosis he strove for the same goal and would succeed as soon as he was able to suppress his erections *To sum up, in the prepsychosis H was unable to master the dangers which, in the psychosis, he fought much more successfully*¹³

In the foregoing discussion, we have placed the castration danger at the center of the delusion formation Now we shall want to discover what means H used to fight this danger

It is an old established truth in psychiatry that a delusion has reality value for the patient and cannot be influenced by intellectual arguments

¹³ In the comparison between the prepsychotic period and the psychotic period we did not include the third prepsychotic subdivision namely that of the dressing ceremonial There was no psychotic period that corresponded to the dressing ceremonial The development of the patient's psychosis had not gone far enough to produce a corresponding psychotic state Such a development would have been possible only if the patient had reached the point of becoming King of France etc. If the patient had reached this point it is quite probable that we would have been able to gain further insight into the symptoms of the dressing ceremonial

The case of Schreber is highly comparable to that of H Schreber however went much farther in his psychotic development Accordingly we hope that our study of Schreber's later development will shed some light on the possible structure of H's dressing ceremonial

Therefore, reality has lost its influence upon the psychotic's trend of thought. Psychiatrists are also familiar with the fact that in a psychosis the conflicts are more conscious than in a neurosis: that the unconscious is laid wide open to the observer's eye. Freud expressed this impression in a revealing way: 'The psychoanalytic investigation of paranoia would be altogether impossible if the patients themselves did not possess the peculiarity of betraying (in a distorted form it is true) precisely those things which other neurotics keep hidden as a secret' (4, p. 387).

Let us consider the first group of delusions. H. believed himself persecuted by his father. His ego defended itself against the same danger as in the prepsychotic state, only in a different way. We may choose between two different explanations, (A) and (B), of this process of delusion formation.

A. The ego uses projection as its defense. We may conceive of this projection as a defense against the unconscious urge for femininity. The ego tries to keep this urge hidden in the unconscious (the id) and consequently H. accuses his father of wanting to castrate and then to abuse him.

By accusing the father of having homosexual desires, the ego denies that it has the same unconscious desires. In order to keep up this denial, the ego has to reveal that it feels threatened by homosexual dangers. This situation proves that the repression has weakened: a fact which we encounter also in prepsychotic conditions. The ego then uses projection instead of the abandoned repression.¹⁴

Does this explanation make clear why a delusion has reality value and why it cannot be affected by intellectual arguments and does it give us insight into the betrayal of the unconscious secrets?

This description about the development of symptoms fits within the frame of the neurosis: for the ego warding off an unconscious urge acts in this way in order to maintain contact with reality. This proves that reality testing has not been abandoned. Even the fact that the ego betrays the secrets of the unconscious through the particular defense mechanism of projection is not at variance with neurotic principles: for the difference between a delusion and a neurotic symptom is not to be found in their content but in their mechanism. Our explanation does not reveal the difference between a neurotic symptom and the delusion.

¹⁴ It is obvious that "the ego defense of accusation by projection" represents only a general pattern. Processes of great variety may fit within its frame. For instance, it may happen that the superego accuses the ego of having forbidden unconscious desires. As a result, the ego may try to prove that another person is guilty of the same fault in order not to feel so guilty himself.

Yet our patient had lost his superego already during the prepsychotic phase. Accordingly the structure of his process was of much simpler nature. The ego projects here from fear of emasculation.

B We may begin with the same statement as in explanation A, that the ego uses projection as its defense. Through projection the prepsychotic conflict between the ego and the unconscious feminine urge has become conscious in the delusion. The originally unconscious urge and the danger of castration connected with it are represented now by H's father. The conflict between the ego and the unconscious feminine urge is exchanged for a conflict between the ego and the father: the inner conflict has become an outer one.

Next, it may be noted that what the father represents (and what causes H so much anxiety) does not belong to objective but to subjective reality. What is now outer world was originally a part of H himself. A part of the mind has been exteriorated (projected) and is treated as outer world.

The attributes of reality which play a role in H's delusion are projected parts of his own personality. His new subjective reality is a part of the domain of his narcissism. As far as his psychosis is concerned, H has severed the ties with objective reality and has built himself a new reality.

Why did this cleavage between the ego and objective reality occur? We are already prepared to answer this question. We have followed the development of the ego during the prepsychotic state. We have noted its weakness in that it was unable to rely upon an oedipal attachment, which would have meant a safe anchorage in the harbor of reality. Because of this development the ego also missed the support of the superego. The danger of castration separated it more and more from reality. Although we lack understanding of the third prepsychotic period, we may assume that the separation continued and that the outbreak of the first psychotic symptoms was a sign of the formation of a new delusional reality.

How did the process of psychosis affect the ego? This question is not a superfluous one, as under normal conditions the development of the ego and of reality go hand in hand. The ties with reality were broken only because the ego shriveled up. The ego fell back upon a very primitive form of projection: it treated a part of the id as if it were outer world. From this analysis we may draw some far-reaching conclusions.

The first question to ask ourselves is: what type of projection is this?

In attempting to find an answer, we must proceed from the hypothesis that in the undeveloped mind of the baby the ego is lacking. The primitive mental functioning occurs through the pleasure-displeasure principle. Every stimulus which causes displeasure is considered as outer world (5, p. 15). The implication is then that a stimulus coming out of the inner world, but causing pain, is regarded as being outer world. The decision as to what is to be considered inner world or outer world is made by a primitive form of projection. This process is a transitory one, the ego

very soon learning to differentiate better between the self and the outer world. It is very important for our understanding that we recognize this projection as taking place in the still undeveloped state of the mind. The normal development towards better judgment is not interrupted or hindered by any fear of impending danger.

Let us now examine the psychotic form of projection. The psychotic mind is forced to make use of this projection because the insurmountable castration danger has severed the relation between the ego and the outer world. It is true that through this projection the psychotic gets rid of the dangerous urge towards femininity in the same way as the baby tries to project the pain-causing stimuli. The great difference between the psychotic state and the undeveloped state of the infant is that the psychotic cannot return to objective reality, whereas, for the infant, all ways to further development are open. The danger which caused the patient to lose his contact with reality presents itself again, as soon as he attempts to return to objective reality, and prevents such return. Therefore, the psychotic mind is sentenced to an absolute narcissism, and the psychotic development excludes learning by experiment. Accordingly the psychotic mind uses the primitive form of projection under quite different circumstances than does the infant.

Within the boundaries of the psychosis the ego has lost its neurotic mechanisms of defense: the mechanisms are no longer cathected. An ego which is in contact with objective reality does not exist in the psychotic part of the personality. With the disappearance of this reality ego, reality itself also disappears.

This trend of thought must be supplemented by a discussion of what happens to the urge towards femininity which belonged to the id. The id has been drained of this urge. Our conclusion is that the psychotic outer world is formed by projection of this urge. The patient no longer possesses *the urge for femininity, but his father wants to force this femininity upon him*.

We may continue this trend of thought with the following conclusion: that his father himself represents the patient's masculinity. He wants to have intercourse with the patient after he has transformed him into a girl. Thus the wish that the masculine component of his bisexuality would have intercourse with the feminine one is completely projected into the outer world.

We may form a conception of how this process takes place. In the withdrawal from reality absolute narcissism is established, in which all cathexes of ego and id insofar as they belong to the affected part of the personality are withdrawn. This part of the psyche has regressed to its original, wholly undifferentiated situation. Through the subsequent at

tempt at restitution, the withdrawn energy is used for the creation of the new psychotic ego as well as of the new subjective outer world

The psychotic projection is then a sequence of two processes, namely, one of *decathexis*, followed by one in which *recathexis* takes place. In the second process ego defenses are recathected and also the new outer world is built from recathected parts of the id. It would be wrong to think that the defenses of the psychotic ego are merely borrowed from the prepsychotic state. The prepsychotic ego is already abandoned so that in the psychosis all defenses are newly built or recathected old ones. Such a defense, for instance, is the warding off of the presumed homosexual attacks by H's father. We are left with the concept that a new building is erected, but it is built out of the stones found in the ruins of the old personality.

We must always keep in mind, however, that not the whole mind has become psychotic. Sometimes large areas of the mind remain normal or neurotic while other parts remain in a prepsychotic state.

In my conception of the psychotic part of the personality the reality ego, the id, and the normal reality are no longer present. A complete regression of the affected parts of the personality has taken place to the extent that there is no differentiation at all. A psychotic attempt at restitution then follows, which causes a new but now psychotic development.

It is clear why this attempt at restitution has to take a psychotic form. The danger of castration, which was related to the feminine urge, cannot be conquered by means of reality. The ego has been forced into deeper and deeper regression until finally reality has become lost. Unless a spontaneous recovery in the sense of increase of ego strength takes place, the same danger will prevent the recathexis of normal reality.

What is the origin of the attempt at restitution? To answer this question, we must ask ourselves another. What compels the young individual to develop? The outer world exerts a great influence upon the baby and impels it to still further development. This process would not be possible were it not for the existence of an inner impulse which turns the young child towards reality.

Freud presents an interesting hypothesis about this compelling force in "*The Ego and the Id*" (7). The antithesis between the life and the death instinct leads to an attempt on the part of the life instinct to direct the destructive tendencies towards the outer world in order to escape self-destruction. An inner conflict between these two basic instincts gives birth to a compelling force towards contact with reality (7, p. 66). I do not want to penetrate further into this difficult field. Whatever the origin of such a force, we may assume that it is present not only in the infant but also in the state of regression in the psychotic mind. It is from this source that the

attempt at restitution receives nourishment. The castration danger separates the psychotic mind from normal reality, but this compelling force then makes its attempt at restitution, through creating a new reality by means of delusions.

We have discussed how, in the content of his delusion, our patient struggled with the same danger as in the corresponding prepsychotic period. It is now clear that in the patient's attempt to create a new reality he had to solve those problems which were left over from the prepsychotic phase. The solution of those problems, of course, occurred always in a psychotic way.

After this long theoretical digression, let us return to the problem under consideration. In my opinion, the explanation given under (B) fulfills the conditions discussed on pages 201 and 202. The rupture with reality and the creation of a new subjective reality make clear why the delusion has reality value for the patient and why he cannot be influenced by arguments of logic. The patient cannot be reached by us across the gulf of separation. The attempt at restitution uses the projection by which the unconscious urge has become conscious, and it is for this reason that psychotics reveal openly what neurotics usually conceal from themselves and from others.

Let us now turn our investigation to the megalomaniac ideas. We have seen that H, by accepting castration in the future, expects to free himself from his persecutions and that at the moment he is freed, his "maja" (mother) will return to him. Again, just as in the corresponding prepsychotic phase, H was unable to develop any activity of his own, so now he has to wait until his mother imago returns to him. The return of his mother imago will be the sign that he has fulfilled the requirements for freeing himself from the persecutions.

Concerning the interpretation of the mechanism of his delusions of grandeur, two different explanations are possible, (A) and (B), just as was the case in our investigation of the persecutory delusions.

A. We already have discussed the fact that acceptance of castration by the ego may be expressed in two different ways: (1) identification with the executed father imago or (2) transformation into a woman in order to become the female sexual partner of the father. This double meaning enables the ego to keep the feminine attitude repressed. Acceptance of the role of the executed father imago is a defense by means of which the homosexual urge remains unconscious. Such a defense mechanism does not reveal its delusional character because it does not explain the difference between neurotic and psychotic defense.

B. We may start with a remark about the primary process. It is clear that through the regression by which the ego is dissolved the secondary process has been

abandoned. The attempt at restitution which then follows has only the primary process at its disposal for accomplishing its aims.

Through the primary process it is possible to displace the cathexis from the idea of being a woman to the idea of being an executed (castrated) father figure for both ideas represent castration.

The attempt at restitution uses this displacement and expresses the acceptance of castration through cathecting the idea of being an executed father imago.

We have already seen that at the age of four H relinquished his attachment to his mother through fear of castration. He may regain this attachment because now he is a man who has sacrificed his penis for her.

Through cathexis of the idea of being an executed father imago the attempt at restitution causes homosexuality to disappear for all representations of femininity have lost their cathexis. Within the psychotic part of the personality only that which is conscious is cathected. The id no longer exists.

It is easy to see what has happened. The feminine part of H's personality is recathected and is now represented by the Maja figure. The ego again may contain the masculine component but at the enormous price of accepting castration. Now in the reunion of the patient with his Maja the castrated masculine component of bisexuality has returned to the feminine one. Thus it is an absolutely narcissistic reunion.

This process does not show any connection with reality and therefore offers an explanation of the mechanism of the delusion. The primary process reigns in the conscious. The unconscious has become conscious if the attempt at restitution in order to create delusions recathects unconscious material which by the preceding regressive process has lost its cathexis. (See also p. 206.)

We now have two different explanations of all delusions. The first explanation is based upon a structure of the personality which still contains the basic pattern of an ego warding off an urge in the unconscious. The second explanation does not touch upon such a structure for the unconscious is no longer effective. Both explanations offer an interpretation of the content of the delusion. Only the second one however enables us to understand the mechanism by which the delusion is formed.

The delusion contains a solution of a danger situation against which no defense on a reality basis was possible.

In seeing the delusion as a result of an attempt at restitution we have interpreted this attempt in another sense than during our discussion of the prepsychotic period. The prepsychotic attempt at restitution tried to restore connections with objective reality in order to stop the decay of the personality. The delusional attempt at restitution created a new subjective reality and did not succeed in restoring relations with objective reality but on the contrary led further away from it.

Some points remain to be considered.

1. The first problem concerns the loss of the oedipus complex. H's

delusion reveals that he abandoned his attachment to his mother at the age of four. Still, until puberty, no specific symptom or behavior betrayed that H. was suffering from such an important loss. Therefore, I assume that at the age of four the oedipal attachment was weakened by one or more traumatic events. Yet the latter did not prevent further mental growth.

With the onset of puberty, a regressive process took place by which the weak spot in H.'s development received more cathexis, by which this weak spot became overwhelmingly important in the formation of the psychosis. The description of the prepsychotic phase contains sufficient evidence to show the lack of an oedipal bond. It was because of the absence of this bond that all defensive attempts at warding off the development of the psychosis finally failed.

May we generalize this experience and say that all cases of schizophrenia undergo during the prepsychotic period the loss of the oedipus complex? Although this problem needs further investigation, the fact that the urge toward femininity plays a leading role in schizophrenia points to a definite answer. This urge is in the foreground only because the oedipal attachment has lost its significance. This conclusion is in sharp contrast with some published cases of schizophrenia in which the authors describe the oedipus complex as prevailing. We are fortunate in being able to include our patient H. in this group, for in the future he expects to attain his mother. We have tried to make clear that the oedipus complex in H.'s case is only a pretended one.

2. The next problem concerns the nature of the prepsychotic homosexuality. Is this urge toward femininity comparable with the urge in homosexual perversions? Let us take the well known case of homosexuality in which the patient is strongly attached to his mother. In puberty he cannot abandon his mother in favor of other feminine objects. An identification with the mother takes place, and from now on the patient loves boys, who represent himself. Such cases teach us that whatever strong homosexual preoedipal bonds there may be, the perversion still has to pass through the oedipal stage. This point makes clear the difference between the perversion and the homosexual urge as displayed in the prepsychotic phase. In the latter the homosexual urge has not passed through the oedipal stage.

3. There is another question which occurs to us in regard to H.'s delusion that he had lost his "maja" at the age of four—namely, whether this represents a "return of the repressed." The answer cannot be in the affirmative. We already have shown that through this delusion about his infancy H. prepared the basis for his megalomania in the future. Accordingly the attempt at restitution used infantile memories for its purpose. This

clinical fact is supported by our new insight into the formation of delusions

This childhood memory, after having been transformed in order to fit the purpose which it has to serve, receives its cathexis through the attempt at restitution

One may be inclined to conceive of the delusion about H's childhood as a return of the repressed but such return would be possible only if the memory of the childhood event could be recovered by virtue of the relative strength of its unconscious cathexis. Our explanation excludes the possibility that such development occurred in H's case

4 At the beginning of this article I contended that schizophrenia is not preceded by an infantile psychotic state. I shall try to justify this statement. It is clear that there is no sharp interruption in the development from infancy to the end of the prepsychotic phase. The personality structure of the infantile phases, next to biological factors, necessarily plays an important role in the formation and shape of the prepsychotic phase. At the moment when the conflicts no longer can be mastered by realistic means, a break with reality occurs which never occurs in infancy. The attempt at restitution concerns these same conflicts and they then are solved in typically psychotic ways with the use of those mechanisms which I tried to describe.

The following remarks should be considered as having a *superficial* as well as a *provisional* nature

(a) Criticism of my description of the schizophrenic conflict is to the effect that this conflict is the screen of earlier conflicts in which aggression plays a conspicuous role. My answer is that in the prepsychotic phase the important process is the loss of the oedipus complex whereupon the conflict for the male patient becomes centered around the feminine urge. Early experiences of course may help to prepare the basis for this conflict.

(b) On pages 204 and 205 I attempted to describe the differences between 'psychotic' projection and projection as it normally occurs in the beginning of mental development. One should always be aware of this difference for otherwise one could easily be persuaded to conceive of these two projections as being identical. In this way one could form the concept that the infant in its *normal* development passes through a psychotic stage. It is unnecessary for me to state how strongly opposed I am to this concept which according to my findings is based upon a serious error.

Infantile projection is the first step in differentiation: it is the beginning of reality testing. This differentiation in its further development leads to the establishment of the ego, the superego and the id.

Psychotic projection is a final step: it is the only means left of solving a danger situation which has already caused separation from reality.

(c) It is a far more difficult task to pass judgment on the attempts of a number of child analysts to diagnose schizophrenia in childhood. Certainly it is a favorable sign that they wish to make a sharper differentiation among the various mental illnesses in childhood. Still, it is questionable whether "childhood schizophrenia" has the same structure as the well-known psychosis occurring in later life. Sometimes one gets the impression that the diagnosis is based upon a slight external similarity. But let us exclude such cases from our present examination.

Better (and still falsely) diagnosed as schizophrenia are those cases where the oedipus complex is impaired and the child patients show symptoms resulting from this impairment. It is considered a great scientific triumph if these children later develop a "real" schizophrenia which seems to bear out the early diagnosis of the child analyst. However, I still have my doubts about the correctness of such a diagnosis and cannot rid myself of the suspicion that just as there are differences between the prepsychotic and the psychotic phase, so also are there similar differences between the "home brew of infant schizophrenia" and the schizophrenia of adults.¹⁵

(d) We may ask how psychotherapy with schizophrenic patients is possible when the patient, insofar as his psychosis is concerned, has lost contact with reality. It is clear that treatment must be concentrated upon the non-psychotic part of the personality and must have as its aim the strengthening of what remains of the reality ego. An increase of ego strength will enable the ego to master conflicts better than before. As a result, the necessity for solving the conflicts in a psychotic way decreases.

According to Freud, ideas of jealousy can be present simultaneously in both a neurotic and a delusional form (6, p. 232). The content of both forms is the same, but the mechanisms are different. We may expand Freud's concept and assume that every delusion may be accompanied by non-psychotic ideas having the same content as the delusion itself. I have already tried to demonstrate that two possible explanations of the content of a delusion exist, one explanation fitting into the frame of a neurotic and the other into the frame of a psychotic mechanism. The first explanation, then, applies only to the non-psychotic content; the second, to the delusion. We may conclude further that any interpretation given to the patient of the content of the delusion will never touch the delusion itself but only the non-psychotic idea having the same content. It is my conviction that although during his psychotherapeutic cure the delusions of the patient may disappear, still the psychotic part of his personality remains untouched by interpretations.

(e) We were able to study the problems of bisexuality throughout the prepsychotic and psychotic development of our patient. A comparative study of these problems in various cases of schizophrenia will certainly bring important insight

15. We may even ask ourselves whether such "infantile psychoses" have the same structure as the prepsychotic phenomena. One gets the impression that there is a similarity in ego reactions but that the problem of whether the conflict in both stages is the same remains unsolved. Careful investigations have yet to be made before light can be shed on this problem.

in this psychosis We may finish with a provisional statement That schizophrenia results from the schizophrenic's incapacity to solve the problems of bisexuality in harmony with reality

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THE EFFECTS OF EXTREME DEPRIVATION IN INFANCY ON PSYCHIC STRUCTURE IN ADOLESCENCE:

A STUDY IN EGO DEVELOPMENT¹

By DAVID BERES M.D. and SAMUEL J. OBERS M.D. (New York)*

Ernst Kris(20), in a recent paper, emphasizes the need for experiments to test the validity of genetic propositions in psychoanalysis. In an ideal experiment all factors are kept constant, except one variable whose effects can then be observed. Perhaps fortunately, it is impossible to set up such an experiment with human beings. Sometimes, however, a set of circumstances approximates such an experiment. In this paper we report our observations of such a set of circumstances.

A fundamental proposition which in recent years has been the subject of wide discussion is that behavior and psychic structure in the adult are in a large part determined by the relationship of the infant to the mother. Bálint(3), Benedek(6) and Ribble(23) have described the importance of the early mother-child relationship in the earliest development of the ego in the infant. Durfee and Wolf(9) and Spitz(25, 26, 27), have reported extensive studies on the severe deleterious effects upon the emotional and intellectual development of infants following separation from the mother. In these reports the separation from the mother took the form of institutionalization, and the observations were made during the period of institutionalization. A number of studies have appeared which attempt to determine the later development of children who have experienced varying degrees of institutionalization in infancy. These reports have carried the follow up studies to different levels of development. Lowrey(22) studied a group of cases immediately after discharge from the institution. Bender(4, 5) has described such cases as observed during latency, and Goldfarb(14, 15, 16) up to early adolescence. Except for Lowrey's paper(22), these reports are unanimous in stressing the irreversibility of the changes produced by the experience of institutionalization.

1 From the Youth Service Department, Jewish Child Care Association of New York.

2 We wish to thank Miss Sarah Sussman, Director of the Youth Service Department and Miss Julia Goldman, Director of Child Guidance for their help and co-operation in the course of this study.

In these reports, also, the authors emphasize the uniformity of the clinical picture in all the children observed

The present study is concerned with a group of adolescents and young adults who were separated from their mothers in their infancy and placed in an institution for varying periods of time up to four years. These cases have remained under the care of one agency from their infancy to the present time, except the cases over twenty one who were discharged at that age. The records of their whole life development have been available to us. Our interest is focused on the relationship of the psychic structure as observed in adolescence to the experience of separation from the mother by the prolonged period of institutionalization. We have made the problem of institutionalization *per se* secondary as we believe that the undesirable results of this type of placement in infancy have been adequately demonstrated by the authors mentioned above.

Our study falls far short of an ideal experiment particularly because there were many variable factors in the development of each child which we could neither control nor directly observe. Furthermore earlier records do not contain data which might have been included were a study such as this projected twenty years ago. Particularly lacking are detailed data regarding toilet training, locomotion and speech development. For these reasons we believe that there would be little value in a statistical analysis of our data. We have chosen therefore to present our material in the form of direct clinical observations.

There are two sets of questions which present themselves throughout our investigation. (1) What clinical entities are encountered? To what extent do the cases vary and what features do they have in common? (2) Are the changes produced by extreme deprivation in infancy irreversible? To what extent can distorted psychic structure be modified in the later development of a child?

SOURCE OF MATERIAL

The Jewish Child Care Association of New York (JCCA)³ is an agency whose function is the placement of children who for various reasons cannot live with their own parents. At one time the agency maintained an infant's home (Home for Hebrew Infants—HHI) but the latter has now been closed for eight years. Our cases were all first placed in this institution. All were subsequently placed in foster homes. Later some went to a country cottage school called the Pleasantville Cottage School (PCS) and an even smaller number to a special school for retarded children called the Edenwald School (ES). Usually between the ages of sixteen and eighteen the children were referred back to their original families or

³ References to the various divisions of the agency will be made by the initials noted in this section.

| Case Present | | | Age Admission to HHI | Age Discharge from HHI | Diagnostic Category |
|--------------|-----|-----|----------------------------|------------------------------|---|
| No | Age | Sex | | | |
| 1* | 20 | F | 9 mos | 9 yrs | Psychosis |
| 2* | 19 | M | 2 mos | 2½ yrs | Psychosis |
| 3 | 21 | M | 16 mos | 3 yrs | Psychosis |
| 4 | 24 | M | 21 mos | 4 yrs | Psychosis |
| 5 | 17 | M | 3½ mos | 4 yrs | Character Disorder (Psychic Immaturity) |
| 6 | 19 | F | 11 mos | 3 yrs | Character Disorder (Psychic Immaturity) |
| 7* | 24 | F | 3 wks | 3 yrs | Character Disorder (Psychic Immaturity) |
| 8 | 22 | F | 17 mos | 3 yrs | Character Disorder (Psychic Immaturity) |
| 9 | 18 | M | 2 mos | 3 yrs | Character Disorder (Psychic Immaturity) |
| 10 | 17 | M | 3 mos | 2¾ yrs | Character Disorder (Psychic Immaturity) |
| 11* | 17 | M | 5 mos | 3¾ yrs | Character Disorder (Psychic Immaturity) |
| 12 | 16 | F | 1 mo | 3½ yrs | Character Disorder (Neurotic Character) |
| 13 | 22 | F | 6 mos | 3½ yrs | Character Disorder (Neurotic Character) |
| 14* | 20 | M | 3 mos | 3½ yrs | Character Disorder (Neurotic Character) |
| 15 | 19 | F | 23 mos | 3½ yrs | Character Disorder (Neurotic Character) |
| 16 | 18 | M | 4 mos | 3 yrs | Character Disorder (Neurotic Character) |
| 17 | 22 | F | 7 mos | 3½ yrs | Character Disorder (Neurotic Character) |
| 18 | 21 | M | 6 wks | 3 yrs | Character Disorder (Neurotic Character) |
| 19 | 18 | M | 5 wks | 3½ yrs | Character Disorder (Neurotic Character) |
| 20 | 18 | F | 18 mos | 3½ yrs | Character Disorder (Neurotic Character) |
| 21* | 20 | F | 21 mos | 3 yrs | Character Disorder (Neurotic Character) |
| 22 | 20 | M | 2 wks | 3 yrs | Character Disorder (Neurotic Character) |
| 23 | 20 | F | 6 wks | 3 yrs | Character Disorder (Neurotic Character) |
| 24* | 23 | M | Under 6 mos | 3½ yrs | Character Disorder (Schizoid) |
| 25 | 18 | M | 3 mos | 4 yrs | Character Disorder (Schizoid) |
| 26 | 21 | M | Under 6 mos | 3 yrs | Mental Retardation |
| 27 | 26 | F | 2 wks | 4½ yrs | Mental Retardation |
| 28 | 26 | F | 2 wks | 4½ yrs | Mental Retardation |
| 29 | 19 | F | 5 mos | 3 yrs | Mental Retardation |
| 30* | 20 | F | 3 wks | 3½ yrs | Psychoneurosis |
| 31* | 22 | F | 6 wks | 3 yrs | Psychoneurosis |
| 32* | 21 | M | 2 wks | 3 yrs | Satisfactory Adjustment |
| 33* | 20 | M | 5 mos | 3 yrs | Satisfactory Adjustment |
| 34 | 24 | M | 7 mos | 4 yrs | Satisfactory Adjustment |
| 35 | 22 | M | 2 wks | 3½ yrs | Satisfactory Adjustment |
| 36 | 24 | F | 7 mos | 4 yrs | Satisfactory Adjustment |
| 37* | 18 | F | 3 wks | 18 mos | Satisfactory Adjustment |
| 38 | 25 | F | 21 mos | 4 yrs | Satisfactory Adjustment |

* Cases marked with asterisk are discussed in greater detail in the text.

were discharged in their own care but for those requiring additional care the Youth Service Department (YSD) was available. Our cases were all taken from the YSD.

This at once introduces a factor of selectivity as many cases which had been institutionalized at the HHI were discharged back to their families, absorbed into other families by adoption or were discharged from the agency later in their lives without requiring continued care in the YSD. It is safe to assume, therefore, that the degree of pathology in our series of cases is greater than might have been found if all cases from the HHI had

been followed. There have been many hundreds of children who have passed through the HHI and it would have been altogether impossible to trace these.

The accompanying table lists the cases which we have studied and indicates the clinical entities encountered. At this point, we may at once emphasize the variety of categories into which the cases fall.

We have utilized psychoanalytic concepts in the study of our cases although none of the cases was psychoanalyzed. We have attempted to examine each case in terms of its psychic structure—that is, the functioning and disturbances of ego, superego and id. We hoped in this way to see if we could contribute some data on the development of the psychic structure, particularly ego development, as influenced by the early separation of the child from the mother. The importance of this approach has been particularly emphasized by Hartmann, Kris, and Loewenstein(18). We have used diagnostic categories for the convenience that this affords and shall discuss in more detail our understanding of the nosological problems involved.

CLINICAL DATA

We shall now proceed to the consideration of individual cases, some of which will be described in detail to illustrate various points. The numbering of the cases in the text corresponds to that in the table.

A *The Psychoses*

We have made the diagnosis of psychosis only in those cases in which the function of reality testing is incontrovertibly damaged. We have found in the individual cases specific features which indicate a relationship between the content of the psychosis and the experience of separation from the mother.

CASE 1 The case is that of a girl who is at the present time twenty years old. She was born out of wedlock and stayed with her mother until the age of nine months at an institution for the care of unmarried mothers. At nine months she was admitted to the HHI where she was later described as a sensitive affectionate child but with some aggressive tendencies and some neurotic manifestations (nail biting). At the age of three years she was transferred to a foster home in which she remained for ten years. Her adjustment for the first four years was considered satisfactory but then she became restless, demanding and over aggressive. There is some evidence that this change was related to the girl's discovering that the foster mother was not her real mother. Following this, there was increasing hostility to the foster mother with overt conduct disorder including truancy, running away from home and stealing. Underlying this whole pattern was the manifest expression of the wish to find the mother. Gradually the girl de-

| <i>Case Present</i> | | | <i>Age Admission to HHI</i> | <i>Age Discharge from HHI</i> | <i>Diagnostic Category</i> |
|---------------------|------------|------------|-----------------------------|-------------------------------|---|
| <i>No</i> | <i>Age</i> | <i>Sex</i> | | | |
| 1* | 20 | F | 9 mos | 3 yrs | Psychosis |
| 2* | 19 | M | 2 mos | 2½ yrs | Psychosis |
| 3 | 21 | M | 16 mos | 3 yrs | Psychosis |
| 4 | 24 | M | 21 mos | 4 yrs | Psychosis |
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| 36 | 24 | F | 7 mos | 4 yrs | Satisfactory Adjustment |
| 37* | 18 | F | 3 wks | 18 mos | Satisfactory Adjustment |
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veloped paranoid ideas Her search for the mother included the expressed desire to find and to kill her in revenge for having been rejected She became involved in antisocial behavior and developed a frank psychotic state for which she was hospitalized

Until the development of her psychotic symptoms the picture was that of an immature ego uncompromising demanding the return of the mother and acting out on the mother figures in her environment her hostility against the absent mother Her psychosis appeared to unfold out of the immature ego structure in the face of the unyielding realities and continued frustrations

The following case is of interest because of the history of a particularly good adjustment during the early period of institutionalization in infancy, and for several years afterward

CASE 2 This is a boy who was born out of wedlock to a psychotic mother He has had no contact with his parents since his birth He was placed at the HHI at the age of two months and remained there until he was two and one half years old His record at the HHI was singularly good He was described as a co-operative neat child not seclusive presenting no problems He was placed in a foster home where his behavior was considered exemplary and there were no problems until he was fourteen years old He was an intelligent child with an I Q of 128

His symptoms began at the age of fourteen when he developed food fads and became aggressive and brutal to his dog He terrified his foster parents who nevertheless tolerated his behavior He had no friends, and stayed indoors all day listening to his radio and reading He presented evidence of thinking disturbance, preoccupation with problems of masculinity and femininity and other intellectualizations He had ideas of reference, and he accused the foster father of having sexual relations with his dog He was diagnosed as schizophrenic and admitted to a mental hospital At the hospital he improved sufficiently to permit his discharge and placement in a new foster home He stated then that he dated the onset of his difficulties from the age of seven when he learned he was a foster child and that since then he felt unloved

The boy showed strikingly little disturbance from his institutional experience according to the records of his behavior at the time of discharge His absorption into a family which accepted him wholly would appear to have been a fortunate circumstance We are told however, that the patient slept in the same bed as his foster parents until he was six years old

It is perhaps of some significance that of the four psychotic cases three were separated from their mothers at the age of nine months or later, two after the age of one year We do not feel justified in proposing any conclusions from these limited data, but it is striking that in all the cases of psychosis, except in the one just presented, there was the opportunity of developing some kind of libidinal attachment prior to placement at the institution In this last case, separation took place two months after birth, but an unusual libidinal attachment to the foster parents developed

Our four cases of psychosis were all schizophrenics. The small number permits us to make only a few general comments. From the psychoanalytic viewpoint, the central pathological process in schizophrenia is the regression of the ego. We were impressed with the relationship of this disintegration of ego function to the underlying maldevelopment of the ego, particularly in the first case. The cases in the following section present the maldevelopment of the ego without loss of reality testing. Except for the provocative observation that the psychotics on the whole were admitted to the HHI at a later age than any other group, we can offer no explanation why these individuals developed a psychosis rather than any of the other types of reaction.

B *Character Disorder*

The largest number of cases which we observed can best be classified under the heading of Character Disorder. We use this designation in the sense of the psychoanalytic concept of character which defines it in terms of the functioning of the ego. Fenichel(11, p. 467) states

Thus the ego's habitual modes of adjustment to the external world, the id and the superego, and the characteristic types of combining these modes with one another, constitute character. Accordingly character disturbances are limitations or pathological forms of treating the external world, internal drives and demands of the superego, or disturbances of the ways in which these various tasks are combined.

We have arbitrarily grouped our cases into three subcategories. The first is that of psychic infantilism or immaturity. In this category, we deal with cases in which it appears to us that the ego and correspondingly the superego have developed inadequately and function on an infantile and archaic level but without evidence of intrapsychic conflict. The second subcategory is that of neurotic character. In these cases there is evidence of a conflict within the individual although the individual himself may not be aware of such a conflict. The third subcategory is the so-called schizoid personality in which the evidences of narcissistic regression present themselves in the symptomatology of hypochondriases or disturbed object relationships but in which reality testing is retained.

The cases in this group, particularly those in the first two subcategories, correspond to cases which are frequently diagnosed as psychopathic personality. This controversial designation is gradually being clarified and replaced by more accurate diagnoses as the psychodynamics of individual cases are more carefully studied [Fenichel(11, p. 373), Greenacre(17), Friedlander(13), Bromberg(7)]. We have therefore chosen not to use the diagnosis of psychopathic personality but to discuss our cases in terms of their psychic structure.

1 *Psychic Immaturity* The concept of psychic immaturity has been discussed by some authors (Deutsch, 8), but in our opinion has not received sufficient clinical attention. We shall first present several cases that we believe can best be placed in this category.

CASE 7 This was a girl whose mother died when she was born and who was placed at the HHI at the age of three weeks. The child had no contact with her family until she was six years old and then met her father who introduced himself as her uncle. She went to a series of foster homes after the age of three but failed to adjust, and at five was referred to an institution for mentally defective children. On an intelligence test at the age of five she was classified as a moron with an IQ of 59. When she was examined at the age of eighteen she had a marked reading disability. The clinical picture was that of an immature infantile personality. There were many other features of disturbed ego functioning including an inability to form object relationships and to accept realistic limitations. She was markedly demanding of attention. Her IQ at this time despite her reading disability was 105. With remedial reading, some psychotherapy and a great deal of casework, extending over three years, this girl was able to carry through successfully a course of study in an art school and she is at present successfully employed in her field.

The striking feature of this case was the nature of the patient's object relationships. She behaved as though she had no ego of her own. She was ready to accept the suggestions of anyone who tried to influence her. She was ready at one moment to go with a girl to another city to become a photographer because the other girl was a photographer. When she met a man who told her he would teach her how to become a successful saleswoman, she accepted his proposition without any regard for the dangers in the situation. Actually it turned out that the man was the leader of a white slave ring and the girl avoided involvement in prostitution only by her naive disclosure to her caseworker of what had been going on. The girl knew in discussion quite clearly the nature and consequences of her behavior but exercised no judgment of her own. Her motor behavior was also indicative of an immature ego. She was hyperactive in the way that a flighty child would be. We see therefore in this case disturbances of the ego functions of motility, perception, intellect and judgment. Her relationships to people were in the nature of transient identifications. The similarity of this case to those described by Deutsch(8) and Greenacre(17) is evident.

This case which is so characteristic of the entire group may be summarized in the following terms which also have been applied to cases of psychopathic personality. There is an adherence to the pleasure principle rather than an acceptance of the reality principle. There is an inability to tolerate frustration, a demand for immediate gratification of instinctual impulses. Evidences of guilt appear to be absent. The patient complains of anxiety only in the presence of objective danger. Object relationships take the form of superficial and transient identifications. Superego de-

velopment is weak and the ability to sublimate is limited. School work is poor and work performance is unsatisfactory. Antisocial behavior is frequent and often the result of identification with criminal persons. Sexual relations, when they exist, are of a dependent nature or take the form of perversions.

The case which has just been described assumes particular interest because of the improvement which was effected. This raises a question to which we will refer repeatedly in this paper, namely, the modifiability and reversibility of the ego disturbances which have developed from the extreme deprivation in infancy.

The following points in this case deserve emphasis: the reversibility of severe intellectual retardation even without direct psychiatric treatment, the development of potentialities in ego functioning as evidenced in the ability to work toward a difficult goal in an organized way, the improvement of this patient's behavior and object relationships. Her hyperactivity disappeared. She became a personable, well-dressed young lady and though far from normal, she was able to establish more stable relationships with young people of her own age.

A similar case, but with less fortunate results, is the following:

CASE 11 This is a boy who was born out of wedlock and was separated from his mother when he was five months old. He was then placed at the HHI where he remained until he was three and one half years old. Then followed a period in foster homes in which he made very poor adjustments. The mother, who was only seventeen when the boy was born, was ambivalent in her attitude towards him and was unable to take him home with her or to give him up for adoption. She also manifested considerable jealousy in his various placements. The boy in his early years at the HHI was described as shy, affectionate and quiet, but as soon as he was placed in foster homes he became hyperactive and aggressive. At the age of eleven he was placed at the PCS where he again adjusted poorly. Here it was especially noted that he was aggressive, was frequently in fights and did not succeed in forming any satisfactory relationship with the caseworker. At the age of sixteen he was referred to the YSD and an attempt was made to place him in a boarding home. This attempt did not succeed. The boy stopped going to school. In the boarding home he refused to obey any rules, came and went as he pleased and was extremely demanding, especially about food. He was aggressive and constantly got into fights. Only rarely did the boy admit to any feeling of unhappiness or of being troubled. He expressed a great deal of resentment toward his mother. He felt that she had been very unfair to him, particularly that she did not give him money. He saw himself as a person who is uncontrolled. If he got pushed around, he pushed right back. He stated that he had no close friends but was a member of a gang. He was unable to take an active part in planning for his future. At the same time, he resented any planning that was done for him.

In this case we have an example of disturbed ego and superego development. This boy, from his earliest infancy, did not succeed in forming any relationship with an adult person through which he could, by the process of identification, develop his ego and superego. We see at the age of sixteen an antisocial character structure. The ego is dominated by the pleasure principle. He reacts immediately to any frustration with aggression. His libidinal development seems to have stopped at a pregenital level. His ego ideals are dim and poorly focused. He shows little superego strength and there is some probability that he is already involved in delinquent behavior.

We included seven cases in the category of psychic immaturity. This group did not differ significantly from any of the other groups in such factors as age of admission to the institution or length of stay in the institution. Five of the cases were admitted at the age of five months or younger, one at eleven months and one at seventeen months. All except one stayed in the institution two years or longer. One remained for one and one half years. In five of the cases, a parent remained interested in the child but usually in some disturbing way. Foster home experiences after the period of institutionalization varied so that no consistent pattern can be described. These cases in which the common characteristic is the disturbed ego and superego development, are the ones most characteristically described as the result of institutionalization. We believe that some degree of this type of ego disturbance is to be found in all our cases. As may be expected, not all of the cases manifested the improvement noted in Case 7. However, five of the seven cases showed considerable improvement in social adjustment, though the improvement in all cases was not manifested until late adolescence.

2 *The Neurotic Character* We have found it very difficult to determine in any individual case the total absence of intrapsychic conflict which would allow us to make a sharp differentiation between the subgroups of character disorder and to place a given case either in the group of psychic immaturity or neurotic character. We find ourselves on this point in agreement with Alexander(2), Staub(28) and Greenacre(17, p 495). The latter says,

It has been said that the psychopath has no guilt feelings, no conscience (the potentialities of a conscience have never been internalized and what remains is only a fear of external punishment) and no psychic mechanisms of defense. Some descriptions state that he has no anxiety. If all this were true I believe that the psychopath would not live very long but would explode from the force of his own primitive aggression. It would seem that these characterizations may be due either to attempts to place the psychopath too precisely as a clinical entity in psychiatric nosology and psychoanalytic

theory, or to see a special group as representing the whole group, and in general to therapeutic discouragement on the part of the doctor with a consequent retreat to a descriptive point of view

The last patient discussed (Case 11), whom we left in a state of therapeutic pessimism, in the last eight months since he has been under our observation, has begun to manifest increasing evidence of conflict. He complains that he is restless, forgetful, unable to find himself and has requested psychiatric help after rejecting it when it was first offered to him.

In the following case, the character disorder was more distinctly colored by the neurotic conflict.

CASE 14 This boy's mother suffered from tuberculosis at the time of his birth and he was separated from her almost immediately. The father, though described as an alcoholic and irresponsible, manifested a considerable degree of attachment and visited the boy frequently. The child was admitted to the HHI at the age of three months and was discharged at the age of three and one half years. At that time the question of placing him with his grandparents was considered. However, this plan fell through and he was placed in a foster home. Within three months the child was in three different homes. He was hyperactive and aggressive; he had temper tantrums and was enuretic. There followed a series of foster home placements but the boy failed to adjust in any of them. The father's interest in the boy gradually diminished and by the time he was twelve years old the father disappeared from the picture entirely.

In his latency period the boy's behavior continued in the same aggressive pattern with the additional symptom of stealing. He got into frequent fights. He threatened his foster parents and once attacked a caseworker. At this time he was taken out of the foster home and placed in an institution, and he verbalized his feelings as follows: "I am a bad boy and my foster mother does not like me." His father had been visiting him at this time and taking him to bars on his drinking bouts. This was a source of humiliation to the boy. He ran away from the institution several times back to his last foster home and also made a few abortive suicidal attempts.

At this time, he developed a new symptom, which was acting the role of a buffoon at school and among his companions. His habits were dirty and sloppy and he would present himself as the butt of jokes and ridicule. He was often depressed especially about his father and felt some responsibility for his father's difficulties. Other symptoms included nail biting.

He developed a striking gift of mimicry and clowning which gained him considerable acceptance by his contemporaries. His defenses were a combination of denial and projection. He developed a hobby of going to moving pictures and kept a fantastically detailed account of every picture he saw in notebooks. He was very proud of this collection and received public recognition for it. His interest in the movies reached a point where he decided that he wanted to become a stunt man. He succeeded in developing considerable skill in this field and, with a Negro boy who was his companion, would stage simulated fights in the streets.

that would gather large crowds. However, he never followed through his ambition to make this capability a professional asset, though he kept up a correspondence with famous Hollywood stunt men.

Various attempts at psychotherapy were unsuccessful. He would accept at the moment the opinion of the examiner that he was in need of treatment. This appeared to be, however, an expression of his compliant, passive attitude and not a matter of conviction. He never remained with any therapist for more than a few sessions. He gradually refused any contact with the agency when his demands for money were refused. *The last contact with him was followed by an abortive suicidal attempt after his expressions of love for a radio actress were rejected.* Actually it is not certain that any such attempt was made. The boy's attitude following this episode was one of unconcern and denial. Only a few days after the alleged attempt, he was back in his usual good spirits. He refused psychotherapy and continued in his pattern of dependency and failure.

In the foreground of the clinical picture is the impulsive acting out by this boy of his neurotic conflict. The masochistic coloring, the submissiveness (latent homosexuality), are probably related to his frustrated libidinal attachment to the father. We would speculate that in this case the continued relationship to the father throughout the boy's formative years created a neurotic conflict which expressed itself in the symptomatology described. The infantile ego structure, with its intolerance of frustration and need for immediate gratification (though the latter be masochistic), gives prominence in the clinical picture to the impulsive acting out.

The neurotic conflict which is evidenced in these cases invariably contains features related to the traumatic experience of separation from the mother in infancy as is illustrated in the following case:

CASE 21. The case is that of a girl whose mother was a feeble-minded woman subsequently admitted to a state hospital with a diagnosis of mental deficiency and psychosis. The father deserted the family when the wife was pregnant and has not been heard from since. The patient lived with the mother for the first twenty-one months of her life and it was reported that her mother mistreated and beat her. She was cared for mainly by the maternal grandmother.

Her behavior at the HHI was considered satisfactory. At the age of three, she was transferred to a foster home and for a while made a good adjustment. About a year later, however, she became enuretic and aggressive. She was placed in another foster home and during this period the mother appeared in the picture frequently interfering with the relationship in the foster home. On the whole, the child seemed to be getting along fairly well, though there were some references to her aggressive behavior. When she started school, at the age of six, the symptoms became more prominent. She was disorderly and stubborn at school, aggressive in relationship to other children, frequently assaulting and biting them. During this period, the foster mother insisted that her behavior at home

was exemplary Suddenly when the girl was about nine the foster mother complained that she had changed that she was no longer getting along with the foster sister and other children in the home She now began to verbalize a wish to return to her mother who had remarried and had a new family In reality the mother's contacts with her were most unsatisfactory After several more unsuccessful foster home placements an attempt was made to return the girl to her home where she remained for a year but the undisguised rejection by the mother ruined this effort She was placed at PCS where again she made a poor adjustment temper outbursts aggressiveness and inability to get along with other children were outstanding symptoms The drive to return to the mother remained prominent

She was subsequently referred to the YSD and placed in a boarding home The outstanding symptomatology at this time was her difficult behavior and her aggressiveness However she herself verbalized a sense of uneasiness especially because of her inability to form any attachments The drive to return to her mother began to take a form of pseudo sublimation in her wish to become a nurse's aide She said she wanted to work with children in order to give them what she had herself not received However a number of attempts to give her the necessary training did not succeed because her temper outbursts when she was criticized or thought she was criticized made it impossible for her to stay on What stood out behind the facade of antisocial behavior was a reaching out for help and support She became involved in complicated relationships with men all in the same pattern These relationships were characterized by fantasies that these men would marry her provide her with jewels and security and all her troubles would be over Guilt feelings were present though transient especially about her sexual activities and several times she asked to be hospitalized in an effort to be protected from her instinctual drives There were persistent pregnancy fantasies She became increasingly obese and was sloppy in her dress

In one of her escapades she was placed by the Wayward Minors Court in a custodial home There her temper outbursts took so severe a form that she was sent to a state hospital In the hospital she fought vigorously for several days until she learned that such behavior was futile and then became a model patient Her explanation of her violent behavior was What else was I to do when they held me down? There was no evidence at this time of any psychosis and the behavior could be understood quite fully on the level of impulsive acting out

This girl although physically separated from her mother at the age of twenty one months really suffered an emotional separation from the moment of birth The father had deserted before the girl was born the mother, herself psychotic and feeble minded had little to offer the child Throughout her whole life we have evidence that this girl never succeeded in forming a satisfactory attachment to a mother person She was unable to experience the identifications that promote growth into normal adolescence We note the continuation of primitive, impulsive wishes and the weakness of her ego structure, which could not tolerate frustration nor

accept the demands of reality. Her superego development is on the level of that of a small child whose only wish is to please the parent and to retain the parent's love.

Her basic orientation was around the wish to be restored to the mother whom, in the psychological sense, she lost in her early infancy. It is the more striking that although the contact with the mother for twenty-one months was obviously minimal, inconsistent and even traumatic, it was enough to leave the girl with an unfulfilled wish to retain it. We see the inability to control her appetite resulting in a marked obesity. We see a constant drive to give to other children that which she herself did not get. She said in one interview, 'I don't like to see children get pushed around. I was pushed around all through my childhood.' Her sexual activity was not sexual activity in a genital sense. A man was to her a source of potential security, a substitute for the mother. The agency, too, served only as a supply of love. She turned to the caseworker repeatedly for help and advice but was unable to accomplish any move on her own. In this case psychotherapy did not result in any improvement.

Twelve cases presented the picture of neurotic character. In this group there was no significant difference regarding such factors as age of admission to the institution or period of institutionalization. In a large proportion of the cases the child was involved with a real parent in a disturbed libidinal relationship and this appeared to be of considerable importance in the development of a neurotic conflict. Levy(21) has emphasized the disturbing effect of an interfering parent in a placement situation. Such a conflict, when combined with the psychic immaturity which these patients present resulted in the picture of neurotic character rather than a psychoneurosis or an uncomplicated psychic immaturity. The infantile ego structure with its intolerance of frustration and need for immediate gratification gives prominence in the clinical picture to the impulsive acting out.

3 *Schizoid Personality* There were two cases in which we made the diagnosis of schizoid personality. We have placed this group under the heading of Character Disorder because we were impressed by the relationship of psychic immaturity to schizophrenia. This problem is far too complex to be discussed here, but our experience would lead us to agree with Helene Deutsch(8) who has also emphasized the relationship of schizophrenia to the ego disturbance of the patient with psychic immaturity. The first case of schizophrenia described above (Case 1), went through a period before the development of an acute psychosis which would have permitted a diagnosis of character disorder with psychic immaturity in the sense that we have described it. Anna Freud(12), also, has brought out that the ego disturbances of adolescents, which are part of

normal development, may often assume bizarre expressions that suggest schizophrenia. The possibility that in all these cases we are dealing with a single process, a disturbance of ego function in various degrees of manifestation, appears to warrant further investigation.

In the first of the cases in this group, the outstanding picture was that of a marked hypochondriasis.

CASE 24 The mother of this boy was psychotic. He was admitted to the HHI when he was less than six months old, after his father died. He was discharged from the HHI at the age of three and one half years and did poorly in a series of foster homes because of his uncontrollable behavior. At the age of six he was placed in a foster home with his oldest sister and remained there until the age of seventeen. Presumably he established a warm relationship with his foster parents, even though he was described as hyperactive and subject to temper tantrums and anxieties throughout his whole life. When examined at the age of eighteen his outstanding symptom was a marked hypochondriasis: severe headaches, dizzy spells and a fear of going crazy. He had a peculiar posturing of his head and despite repeated negative physical examinations insisted that his headaches were due to pus on the brain or the pressure of bone resulting from a previous mastoid operation. He had no friends and had very few social contacts.

In this case, as in the psychotics previously described, we are struck by the fact that, in the course of the child's life, there was the development of a strong libidinal relationship and that the illness seemed to follow the breaking up of this relationship.

C The Psychoneuroses

The diagnosis of psychoneurosis presupposes an underlying conflict between the ego and unconscious instinctual impulses. It further presupposes, as Freud has shown, the existence of an oedipus complex as the central core of the neurosis. Fenichel(10) has described the atypical oedipus complex which a child brought up outside of a family constellation may experience. The small number of psychoneuroses which we encountered may be due to two factors, first, that the libidinal development in these children did not reach the level necessary for developing an oedipal conflict, and second, that the distortion of the family constellation was so great that a typical oedipal complex did not appear. We cannot, of course, exclude the possibility that the oedipal level was reached, with ensuing regression.

In our series there were only two cases which we diagnosed as psychoneurosis. The separation from the parents in both cases gave to the clinical picture a specific coloring.

CASE 30 This is a girl who was admitted to the HHI at the age of three weeks. The mother was psychotic. The parents visited the child only rarely throughout

her placement and have been entirely out of contact for at least the last ten years. She was placed in a series of foster homes from the age of three and one half but did not adjust in any of them. During her early placements there was constant question about her returning to her parents who, however, openly rejected her. The child would say, "How can anyone want me when my own parents don't?" In all of her placements the question of being accepted was in the foreground. In her last foster home she adopted the names of her foster parents although there was considerable friction between them. The girl was of average intelligence. Her symptoms consisted of fainting spells, abdominal pains, nausea and vomiting, anxieties and confusion and finally, a preoccupation with sexual matters and aversion to sexual contact. A transition to neurotic character was evident in this case in the tendency to become involved in acting out situations by attachments to middle aged men.

In this case, the clinical picture was predominantly that of a psychoneurosis although at no time did the girl form a satisfactory relationship in her foster homes. What was evident was a drive to re-establish infantile relationships to parent figures.

In the only other case in which the clinical picture is primarily that of a psychoneurosis, there was a history of a long and satisfactory relationship within a single foster family. This followed a prolonged period of institutionalization and character disorder in latency.

CASE 31 This girl was placed at the HHI at the age of one and one half months and remained in the institution until the age of three years. Until the age of ten she was in six different homes. She failed to make a satisfactory adjustment because of her aggressive behavior and her demanding attitude. At the age of ten she was placed in a home where she remained until late adolescence at which time she went off to college. The relationship in the last foster home was described as a warm one with a close attachment to the foster parents and foster siblings. Her neurotic symptomatology developed in her adolescence when she became subject to moods, was in a state of confusion, particularly about sexual matters, did poorly at school and was unable to make satisfactory social contacts. She was indecisive and could not make up her mind about her future. She had a number of anxiety attacks. The diagnosis made in this case was that of a mixed psychoneurosis with obsessional features. She received intensive psychotherapy and there was considerable symptomatic improvement. She has gone off to college where she is doing satisfactory work.

In this case we note the combination of a markedly disturbed ego structure, as manifested by the child's early aggressive and demanding behavior which, apparently, was satisfactorily handled from the age of ten until the development of neurotic symptoms in adolescence. The point to emphasize here is that this individual, despite a long history of institutionalization and a character disorder in the latency period, was nevertheless capable of forming strong libidinal attachments.

Without a psychoanalysis we could neither determine the nature of the unconscious fantasies responsible for the psychoneurosis, nor could we establish the relative importance in the neurosis of the foster home experience and the early institutional experience

D *Mental Retardation*

Along with other manifestations of ego disturbance in our cases, we may expect considerable disturbance in intellectual function. The intellectual retardation which results from extreme deprivation in infancy and particularly from institutionalization, has been described by other authors [Goldfarb(14, 15, 16), Bender(4, 5)]. Our material also, showed evidence of intellectual retardation, as measured by psychological tests. However, our material has brought out that, contrary to the findings of other authors, this retardation is not always irreversible and that in many cases striking changes in intellectual functioning were noted. This fact has been mentioned in several of the cases described, particularly in Case 7, in which the I Q changed from 59 to 105. We are not prepared to discuss the reasons for these changes as we do not have enough evidence to permit a direct statement. A number of our cases which, if studied earlier in their lives would have been listed as mentally retarded cases, have subsequently functioned within normal limits.

Nine of our cases have never had an I Q below 90. Of twenty-eight cases in which more than one psychological test has been performed over the years increases of from ten to forty five points have been noted in sixteen. In only two were there decreases of over ten points, three fluctuated, five remained at the same level over the years. Our findings which indicate the reversibility of intellectual retardation, are in accord with a similar study reported by Schmidt(24) whose study, however, was made from the point of view of a teacher.

There remain, in our series, four cases in whom the outstanding feature of the clinical picture is the persistent mental retardation (I Q 75 or less). It is interesting that in all these cases the individuals have made a satisfactory social adjustment. They are all self supporting, leading quiet, if unexciting lives, are able to maintain sustained employment, and fit into the family groups in which they are living. In one of the cases there is some evidence of organic brain involvement and this case has shown a progressive drop in I Q over the years. It may be significant that two of these cases are a set of twins who had the longest period of institutionalization of any of the cases in our series—four and one half years. All of these cases were admitted to the institution under six months of age, two of them at the age of two weeks.

E. *Satisfactory Adjustment*

It is with some trepidation that we approach the description of the category of "satisfactory adjustment." The difficulty that Ernest Jones(19) had in his attempt to define a normal person, with all mankind to choose from, must give some measure of the difficulties which we have encountered in this series of severely traumatized youth. We do not for a moment consider any of these children to be "normal." We are certain that careful psychoanalytic investigation would reveal serious residua of the early experience of deprivation. However, with full awareness of these limitations, we have included in the category of satisfactory adjustment, those individuals who are functioning well, whether in a work situation or at school, who present no evidence of overt disturbance in their behavior or in their relationships within their families or among friends.

We cannot explain with certainty why these cases made a satisfactory adjustment. The factor of age of admission to the HHI does not appear to be significant. Four cases were admitted at five months or less (three under one month), two cases at seven months and one case at twenty-one months. The period of institutionalization was not significantly shorter than in other groups. Family background, also, does not offer any significant difference from any of the other cases. In fact, six of the seven mothers were either psychotic and/or mentally retarded. Four of the cases were born out of wedlock. It may be significant that in all these cases, except one, there was no interest of any family member through the period of placement. As noted earlier, Levy(21) has emphasized the point that interference by a parent in the placement situation may result in a more disturbed picture.

There was a wide variation in behavior through the years in this group, which includes seven cases, from the persistence of severe disturbance from infancy until adolescence (Case 34), to the opposite extreme of no disturbance at any time including the period of institutionalization (Case 35). There are cases in which improvement was noted shortly after discharge from the institution (Case 37) and others in which improvement occurred during latency (Case 33). Although a number of cases in other categories, particularly that of character disorder, did accomplish a considerable degree of social adjustment, we have included in this group of satisfactory adjustment only those cases in which the present picture is outstandingly more favorable.

This group is of particular interest inasmuch as it permits consideration of the question of the reversibility of the psychological effect of extreme deprivation by separation from the mother. It is not important that this reversal be complete. That it is at all reversible is a fact of considerable prognostic and therapeutic importance. Our finding that the changes are

modifiable is at variance with the reports of other authors [Spitz(25, 26, 27), Bender(4, 5) Goldfarb(14 15, 16)] This may be due to the fact that we have followed our cases to an age considerably beyond that of earlier studies

Two of the cases were absorbed into satisfactory foster homes immediately after their discharge from the HHI

CASE 32 One such case is that of a boy of twenty-one who was born out of wedlock to a mother who was psychotic He was admitted to the HHI at the age of two weeks and transferred to a foster home at the age of three years The foster parents were a childless couple who completely absorbed the boy into their home The boy had always regarded these parents as his own although he knew that they were foster parents He has remained with the same family up to the present time At the age of nine he had an I Q of 102 and at the age of seventeen scored an I Q of 124 He had a very good record in high school which he completed in three and one half years At present he is doing brilliantly in college on a scholarship

There are cases in which early foster home placements were unsatisfactory and several years passed before a satisfactory foster home placement was effected

CASE 33 Such a case is that of a boy of twenty who was born out of wedlock to a mother who had been committed to a girls reformatory for sexual delinquency She was mentally defective The boy was admitted to the HHI at the age of five months There he was described as obedient friendly shy and affectionate He was placed in his first foster home at the age of three years He was overtly rejected in his first five placements because of persistent wetting soiling stubbornness and destructiveness His first satisfactory placement occurred at the age of six and he remained for six years with the same family which was described as well integrated stable and affectionate The foster parents maintained a consistent interest in the boy and were understanding in handling him despite the continuance of his symptoms Gradually his behavior in the home improved but he continued to be a problem at school where the teachers were unsympathetic It was characteristic of this boy that every time he was placed in a new foster home he reacted with considerable evidence of trauma and he would insist upon clinging to the name of his previous foster parents until he accepted his new placement At the age of twelve the boy was again placed and many of his symptoms particularly his aggression reappeared for a short time The improvement however was resumed and continued slowly by the time the boy was sixteen he appeared to have made a satisfactory adjustment and was self sufficient He has been attending an industrial college At the present time at the age of twenty there are no complaints about his behavior

The following case is described because it presents a dramatic picture of the development of a child from a severe behavior disorder to a state of adequate social adjustment

CASE 37 This girl was born out of wedlock to a feeble minded mother who had no contact with her. She was admitted to the HHI at the age of three weeks. She was discharged at the age of eighteen months to a foster home. At that time she was described as unresponsive, unable to stand up by herself, without interest in her surroundings, generally restless, but reacting with rage to physical examination. She responded almost at once to placement in a foster home, became active and friendly, and her physical appearance improved. The second placement which lasted six years was less satisfactory, presumably because of the foster parents' rigid disciplinary attitude. The girl developed symptoms indicating a neurotic conflict. She was enuretic; was withdrawn and could not make friends. She sucked her thumb and appeared frightened and timid. This was the picture at the age of nine. In addition, there were temper tantrums. The following placements were more satisfactory and gradually this girl showed improvement in her behavior and adjustment. She remained somewhat unrealistic in her demands but she did well at school, was well liked, and an integral part of the foster family. At the present time she is in a business school.

Our chief interest in this group focuses on the fact that considerable improvement to the level of satisfactory social adjustment was possible following the experience of extreme deprivation in infancy. We may again emphasize that the satisfactory adjustment in five of the seven cases did not become evident until latency or early adolescence. In their earlier years they showed varying degrees of unsatisfactory adjustment, and if our observations had been limited only to those years, we would have had to put them in one of the categories of ego maldevelopment. The implication is that the arrest of ego and superego development which characterizes the cases suffering from emotional deprivation in infancy is not an irreversible process and that further development of ego and superego is possible.

DISCUSSION

We have attempted in this study to describe the psychological picture of adolescents who in their infancy suffered extreme deprivation through separation from their mothers. As we indicated in the introduction, the questions raised by this study fall into two groups:

- 1 The effect on development of psychic structure resulting from the traumatic experience in infancy
- 2 The modifiability of the psychic structure in the course of the child's later development following this early traumatization

Our findings confirm the basic concept of the importance of the early mother-child relationship in the development of the ego and superego. The special value of our study, we believe, is that it permitted us to examine by direct clinical observation a relatively large group of cases, all of whom

suffered a similar experience in infancy. This approximates the setting of a biological experiment, though, as we have stated before, it is far from a crucial one.

Our observations show that the cases fall into a variety of clinical categories, but at the same time, there is in all the cases a similar underlying pathology. It would be an error to emphasize the differences and neglect the similarities, or to emphasize the similarities and neglect the differences.

Previous studies have pointed up the similarities in the psychological results of deprivation. As far as they go, these studies give a true picture of the traumatic effect of separation from the mother. Children who have been deprived of the most important factor essential for normal development—that is, continuous and satisfactory contact with a person who can offer the opportunity for satisfactory identification—suffer a distortion of psychic structure. Our cases can be understood in terms of the functioning of an immature ego along with deficient superego development. Normally the ego functions increasingly in accord with the reality principle and less in accord with the pleasure principle. This development requires the ability to tolerate frustrations and postpone gratifications. Our cases, especially in the group of character disorders, manifested a striking weakness of this function. Disturbances of learning, also an ego function, are to be expected and occur with great regularity in these cases. The importance of identification in the learning process is well known. In our patients, difficulty in establishing satisfactory relationships went hand in hand with difficulty in learning. Object relationships, too, are disturbed and consist for the most part of identifications which are transient, superficial and narcissistic in nature. These characteristics have been illustrated in our case reports.

Our cases have in common the psychopathology of ego and superego maldevelopment. If this common basis is overstressed we find ourselves in the morass of the psychopathic personality, the typical institutional child or whatever descriptive term is preferred with the accompanying sense of therapeutic hopelessness.

If we permit ourselves an analogy from clinical medicine, we find in the variations of the manifestations of tuberculosis, from the mild unrecognized attack in childhood to the extreme of miliary tuberculosis, a common substratum of infection with the tubercle bacillus. As the cases of tuberculosis all have in common the infection with the tubercle bacillus, our cases have in common a distortion of ego and superego function and as the physician treats his patient by utilizing in each case the individual defenses which modify the inroads of the tubercle bacillus, so too, in our cases, it is important to keep in the foreground each individual's

characteristics and his attempts to deal with his psychic maldevelopment

We can only speculate as to why our cases manifest the variety of clinical forms noted. The pure culture cases might be considered the seven cases of psychic immaturity. The nature of the interference of a parent in the placement situation in some cases introduced a neurotic conflict which the immature ego attempted to handle by the development of a neurotic character disorder. In two of the cases the development of the individual progressed sufficiently to present a conflict closer to the oedipal level, with a consequent psychoneurosis. We can only guess whether this further development was the result of fortunate life experiences subsequent to the institutionalization or the result of maturation. The four cases of schizophrenia could be the subject of a separate chapter. We cannot hope to find the answer to the mystery of the etiology of schizophrenia as a footnote to our study, but we note the possibly significant fact that these cases were institutionalized at a later age than other groups.

The most important and most puzzling question is why some of our cases made a satisfactory adjustment. If we add to the seven cases in our group of satisfactory adjustment other cases, including the four mentally retarded, and the majority of our cases of psychic immaturity, we find that by late adolescence about half of our cases have made some degree of favorable social adjustment.

This brings us to the second group of questions that our study has raised, that is the modifiability of the psychic structure that resulted from the infantile trauma. Our results indicate that this psychic structure is not immutably fixed. If we take as a point of transition discharge from the institution, which occurred in our cases between the ages of two and one half and four and one half (except one case at one and one half), after institutionalization for an average period of about three years, we find that considerable growth in ego function is possible in the years that follow. Hartmann, Kris and Loewenstein(18) have pointed out that the potentialities for the formation of personality throughout latency and adolescence have for some time been underrated in psychoanalytic writings. They indicate that the basic structure of the personality and the basic functional interrelationship of the systems of ego and superego are fixed to some extent by the age of six, but that after this age the child does not stop growing and developing and that growth and development modify existing structure. Modifications which we have noted were evidenced in social behavior, in learning abilities and in personal relationships.

Other authors have stressed the permanency of the psychological effects of extreme deprivation in infancy. Our findings are at variance with their conclusions. It is very difficult to compare such studies because there are subtle differences which cannot be measured and which influence the

results in any specific study. A nurse, for example, may by her personal qualities contribute to a group of children the opportunity for libidinal experiences that might be of very great importance or a nurse may favor several children in a group for various reasons. Other factors that make the comparison of our study with others difficult include the following: 1) institutional practices differ from one place to another, 2) our cases were followed for a longer period of time, 3) in certain studies selection was made on the basis of severe existing psychopathology, particularly in the cases studied by Bender(4, 5).

When we survey our cases in the attempt to find any correlations that will permit understanding of the causes of modifications of psychic structure that we noted we are impressed rather by the individual variations. Changes occur with or without psychotherapy; changes occur early and later in life. In some cases changes take the form of continuous improvement, in others of fluctuation in symptomatology. It becomes obvious that available data do not permit any positive correlations at this time. We can do no more than evaluate the factors in each individual case, and suggest tentatively the extent to which the resultant picture in each individual case has been influenced by maturation, satisfactory placements, educational opportunities, casework or psychotherapy. What does come out of this study is the realization that each case requires individual evaluation.

The implications for therapy are evident. The therapeutic nihilism which has characterized the approach to these cases is not warranted if we limit the aim of therapy to increasing of ego functioning to the level of social adjustment. The most important single therapeutic factor we believe to be the opportunity for the development of a close stable relationship to an adult person, whether in a placement situation, a casework relationship or in psychotherapy. In this sense we have been working in the tradition of Aichhorn(1) who emphasized the importance of the transference relationship in the treatment of his wayward youth. The treatment of these cases requires a flexible and a patient approach which must utilize the combined skills of caseworker and psychiatrist. To this extent the therapy of such cases would be very difficult to carry out except with the facilities of a social agency.

Ego development is a relatively new field of study that is being investigated not only by psychoanalysts but also by psychologists and anthropologists. There is only a beginning in the elucidation of the complex factors which influence ego development. The subject has not yet reached that state of finality which would permit closing the door on the hope of change in any individual case.

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ROOMING-IN RESEARCH PROJECT ¹

DEVELOPMENT OF METHODOLOGY OF PARENT-CHILD RELATIONSHIP STUDY IN A CLINICAL SETTING

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I INTRODUCTORY AND HISTORICAL NOTES

The Rooming In Research Project is the designation of a parent child relationship study within the framework of the flexible schedule method of infant care. It acquired its name from the Rooming In Unit, a four bed, semi private room where mothers and newborns are housed together. The Rooming In Unit is strategic as a clinical laboratory for parent child relationship study in that it permits the initiation of flexibility and individuality in the care of mother and infant and offers a natural opportunity for observation of parents especially mothers, in their initial reactions to the newborn child. From the medical point of view, this Unit is a type of hospital service offered to mothers for the care of their newborn babies as an alternate choice to the usual routinized care of infants in the central nursery.

The impetus for a parent child relationship study centering around a Rooming In Project developed in the Department of Pediatrics with an initial planning group of two pediatricians, two psychologists and a psychiatrist.² Actual plans for the Rooming In Unit on the maternity division of the hospital began to take shape in June 1946 when the interest was welcomed and shared by the Department of Obstetrics, the School of Nursing and the Hospital Administration. Procedures for organizing and maintaining the Unit have been regulated through a Policy Committee composed of representatives from these respective departments and a member of the Study group. The first four bed Rooming In Unit was

1 The Rooming In Research Study is being conducted in the Department of Pediatrics, Yale University School of Medicine, with the co-operation of the Department of Obstetrics and Gynecology, the Yale School of Nursing and the Administration of the Grace-New Haven Community Hospital, aided by grants in aid from 1) Mead Johnson and Company, 2) The George Davis Bivin Foundation, Inc., 3) The Field Foundation, Inc., and 4) The Federal Security Agency—U. S. Public Health Service.

2 Grover F. Powers, M.D., Richard W. Olmsted, M.D., Seymour B. Sarason, Ph.D. and the authors.

opened in October 1946(2) and a second similar unit contiguous to the first was opened in October 1948

Quite independently, other centers of rooming in interest had been developing in Washington D C at the George Washington University Hospital(8 4) in four Detroit hospitals through the stimulus of the Cornelian Corner(5) and at the Atom Bomb Project in Los Alamos New Mexico(1) In these four initial undertakings rooming in facilities were developed for psychological reasons and were elective A few months later at Jefferson Hospital in Philadelphia(6) and at Duke University Hospital in Durham North Carolina(3) mandatory rooming in was established for clinic patients for physical reasons to reduce infections among the newborns and to provide them with increased care (mother's care) necessary because of the shortage of nursing coverage Satisfaction of mothers with the plan has been reported whether the initial impetus for development of rooming in was psychological or physical Among the score of other hospitals which have subsequently instituted rooming in psychological impetus has been in the foreground There is thus evidence that in maternity and newborn care a movement has started to humanize hospital experience (7) for mother and infant

Rooming In and flexibility represent ideology in infant care which diverges from the rigid schedule, coercive method dominant in this country from approximately 1910-1940 It appears that the concept of the importance of strict regularity in infant feeding developed concurrently with the post World War I expansion of hospital care for maternity cases and the institution of central nurseries for newborns and that it was accepted as beneficial (or probably necessary) without special appraisal, along with the sanitary safeguards and protection which hospital care offered to maternity and newborn cases It appears also that the institutional care of maternity cases which encouraged the establishment of clock and calory routines restricted the education and experience of doctors and nurses in training since it focused on observance of over all rules, discouraged interest in the individualities of maternity and newborn patients and disregarded extramural follow up in the homes Furthermore, the hospital regulations deprived the mother of close relationship with her infant of practical help in breast feeding and otherwise taking care of the baby, of instruction about its behavior and development, and offered instead the imposition of an impersonal regime in which the nurse took over the maternal prerogative of the infant's early care

The counteraction to regimented methods of infant care has developed increasing momentum within the last ten years from observations and case reports of workers in the fields of child psychiatry, child guidance and pediatrics, who have had to deal with exacting unhappy bewildered

parents and unhappy, disturbed children. The reports and discussions of professional workers in these related fields have stimulated a growing interest in the institution of more flexible infant-feeding methods in hospitals and a consequent return to more natural and considerate child-care methods in homes. (Hospital methods have been carried over into the homes and since practically nine-tenths of all mothers are delivered in hospitals, this influence has assumed tremendous proportions.) It has been hoped, even expected, that such a reversal of procedures would stimulate both professional and parental insight into the early developmental needs of the child and sharpen awareness of the effect of home influence on the child's development (viewpoints which have been dulled by institutional training), and furthermore that such insight and recognition would tend to further the promotion of healthy emotional development of the child within the family circle or, conversely, to reduce the incidence and severity of behavior disorders.

Study is obviously necessary to determine whether such hopes and expectations are justified, to determine, indeed, just what is the response of parents and infants to flexible schedule procedures in child care. It is assumed that parental response to either flexible or rigid child-care methods is determined by past experience and personality of parents and is subject to moderation or exaggeration in either case, so that the underlying fact to be studied is really the relationship between parental attitudes in caring for the child and the child's behavior. The main question therefore is: Can a meaningful relationship be demonstrated between the young child's behavior and the parents' attitude and personality as evidenced in their child-care procedures? Related questions may be phrased in terms of prediction and prevention: If there is a demonstrable relationship between parental attitude in child care and the child's behavior, what are the possibilities of foreseeing and forestalling adverse and distorted reactions in the growing child, of foretelling and promoting normal, wholesome emotional development?

II. GENERAL PLAN OF STUDY

The Yale Rooming-In Study is fundamentally a three-year survey of rooming-in families who have chosen rooming-in, a survey of their home situations, their reaction to rooming-in and flexible schedule, and the development of the child. The study material was planned to include:

- (1) Information about the mother and her attitudes toward the coming child obtained in Prenatal Clinic, and similar information about the father, when possible.

(2) A record of the mother's "remembrances of labor" taken by the pediatrician in the Rooming-In Unit.

(3) Nurses' and doctors' observations of the mother and infant in the Rooming-In Unit.

(4) Observation of the mother and infant in the home situation by the pediatrician in the first post-hospital month.

(5) Record of the mother's and infant's post-hospital history and observed condition at the time of the six-week check-up visit to Pediatric Clinic.

(6) Records from Well Baby Conference of the Visiting Nurse Association.

(7) Annual evaluations near the time of the child's first, second and third birthday:

(a) Psychological and developmental evaluation in the psychologist's office.

(b) Social evaluation based on home visit of a psychiatric social worker.

(c) Parental evaluation of the child's reactions during the preceding year by questionnaire.

The Study was not planned to carry the children beyond three years, but it was hoped that a certain number of them would be under observation at the Child Study Center Nursery School, and that the Rooming-In Study data and the Child Study Center data could supplement and enrich each other. It was obvious to the Study group that more closely spaced observations by trained personnel were desirable. However, in view of the number of personnel available at the beginning of the Study, a decision had to be made between an intensive study of a few selected cases and a less detailed study of a more inclusive number of cases. The latter choice was decided upon for several reasons. The open, friendly atmosphere of the Unit with free exchange of experience between patients made it clinically complicated to handle different categories of interest and follow-up plans. Since parents' reactions to flexible method of newborn care was one of the more immediate items for observation, it seemed important to include many different maternal personalities. This could be insured by including in the Study all mothers housed in the Unit. Also, since the Study as formulated was an exploratory one, a possible bias in the selection of subjects might have been introduced by the use of more rigorous criteria. The observations are intended to reveal favorable and unfavorable aspects of flexible schedule methodology, and to yield clues for the direction of further more detailed and definitive in-

vestigation into the question of the personality relationships between parents, especially the mother, and child

III. CLINICAL FRAMEWORK OF STUDY

The plans for both the research study and for the service organization of the Rooming In Project were initiated together in June 1946. At the very same time the Project assumed a teaching function through the one year assignment of a pediatrician in training to assist in the Project and Study plans, and also through the rotation of student nurses in the Unit under the double supervision of a full time Rooming In Project nursing fellow and the obstetrical supervisor. It was obvious that the triple aspects of the work (clinical service, training and research) imposed severe mutual limitations on each other, especially when the initiation of all three aspects occurred simultaneously. The first question which faced the Study group was accordingly: How within the framework of the clinical services of the teaching hospital can relevant psychological data be obtained to answer the question about a possible meaningful relation ship between parental attitudes and child behavior?

As indicated above, the framework of the clinical services for mother and newborn infant at the Grace-New Haven Community Hospital consists of prenatal clinic, labor and delivery service, hospital maternity and newborn service, including rooming in facilities, nursery interne's post natal home visit(s), postnatal check up in clinic for mother and infant, and finally *Well Baby Conferences of the Visiting Nurse Association*, one of which is held in the hospital. With the appointment of a pediatric staff member as a rooming in fellow to assist with the Project and the parent child relationship study, it became appropriate for him to be the selector of patients both for the Rooming In Unit and for the parent child relationship study, and also the pediatrician for the Well Baby Conference in the hospital where a certain number of the selectees could be followed. The selection of patients for Rooming in took him into the Prenatal Clinic where he easily introduced himself and was readily accepted by mothers on behalf of his interest in the welfare of the coming child.

IV. DEVELOPMENT OF METHODS FOR COLLECTING AND RECORDING DATA

There was thus a framework for continuity of observations made by pediatricians assigned to the Rooming In Project. Continuity of supervision and observation of the selected mothers and their infants by the

rooming in fellow was essential for the Study, and at the same time it served well the purposes of his training and service it offered only a modicum of help, however, in answering the question of how to elicit and record psychological data on patients seeking supervision in the normal pursuit of child bearing and child rearing in obstetrical, pediatric and public health clinic. This is essentially more difficult than obtaining personality data from patients who are seeking psychological guidance. Another limitation in obtaining the desired study data was the inexperience of the pediatric fellow in interviewing for interpersonal relationship data, or of dealing with intimate psychological data, once it was tapped. The Study group accordingly felt that the prenatal interviews should be structured for the guidance of the pediatrician first in accordance with the criteria of selection of mothers for rooming in and secondly, in accordance with the subject matter usually uppermost in the minds of expectant mothers in clinic (as tested out by psychiatrist and pediatrician independently in spontaneous interviews) and finally, when rapport between pediatrician and expectant mother was assured, in accordance with the desired information about the mother's past and present family relationships and attitudes in looking forward to the care of the child. There were in addition the more obvious reasons for structuring the interviews to assist immediate recording of detailed data, comparable from one patient to another, and to insure continuity of methodology in obtaining data for the duration of the Study, with each annual shift of pediatric fellows assigned to the Rooming In Project.

I PRENATAL INTERVIEWS

On the basis of repeated joint consultations of the Study group, a series of six structured interviews were devised for the pediatrician's use in Prenatal Clinic. In planning the questions the Study group kept in mind the need of the prenatal patient for information and opportunity to express her questions, the requirements of the Study for a body of psychological data and the necessity for maintenance of rapport between pediatrician and patient. Without the latter, of course, neither the service nor the Study requirements could be fulfilled. In accord with this consideration the pediatrician initiated each interview with a question as to the well being of the mother, and an expression of his interest in any questions she might have. Each interview was a composite of spontaneous and structured conversation made up of questions which were known to meet the mother's special interests and questions which were primarily for Study interests. The details of the interview questions have been changed from time to time to meet the changing needs of the

Study or of the interviewers. For instance, the original ease and the naturalness of the "Screening" Interview were somewhat sacrificed when the Study group decided that every patient in Prenatal Clinic should be screened for a comparative study of the socioeconomic status of those mothers who elected rooming-in and those who elected nursery care for their infants. The approach to the more intimate family relationship data was reserved for the last interviews. In the preliminary assays of procedure it was noted that introduction of these subjects during the latter part of pregnancy met with a favorable response, as if the mother's thoughts along these lines were already mobilized by the life within her, and that she was glad to discuss them in the waiting period of pregnancy. After delivery her interest was so engaged with a multitude of practical details and with fascination in the presence of the infant that it could not easily be diverted to past considerations.

2. REMEMBRANCES OF LABOR

At the time the Study started, it was not possible to obtain systematic objective records of the detailed reactions of each mother during labor and delivery and her immediate response to the newborn child. It had been observed, however, that the mothers in general tend to pour forth an account of their birth experience to whomsoever is on hand to listen after their return from the delivery room. Therefore the Study Staff decided to record such subjective impressions after the mothers came to Rooming-In. The pediatrician asked each mother to tell about her labor from the moment contractions began, and, in addition, he asked her direct questions about her feelings during labor and delivery and on first sight of the infant. This remembrance of labor interview was taken at the convenience of mother and pediatrician between the first and seventh postpartum day. When the Natural Childbirth Study was started six months after the Rooming-In Study, the remembrance of labor record became of mutual interest to both studies, and the pediatricians tried to meet the obstetricians' interest in obtaining this information from Rooming-in mothers on the third postpartum day. In the event of postpartum complications, the remembrance of labor interview was sometimes intentionally omitted.

3. NURSES' AND DOCTORS' NOTES IN THE ROOMING-IN UNIT

In addition to filling out the hospital record forms, the nurses and pediatricians are requested to write on a daily comment sheet their in-

formal observations of both the mother's and the infant's outstanding reactions. Various forms have been tried to train the nurses' observations and to encourage a *daily record of same from each nurse on duty*, but have been abandoned as impractical and confusing in a clinical setup with rapid turnover of patients and with changing shifts of student nurses every two or three weeks. Aside from the rooming in graduate nursing fellow, all of the nursing in the Unit has been carried out by student nurses. The graduate nurse was therefore instructed as to the type of observations the Study Staff would like to have made, and she transmitted the instructions to the student nurses. They were asked to describe the outstanding features of the mother's general behavior, including her attitude toward the infant and her way of handling it, her reactions and those of the baby during breast feeding periods, her attitude toward nurses, doctors, other mothers in the Unit, and her visitors. They were asked to record any striking comments or content of conversation. The rooming in pediatricians made similar notes. There was thus a continuous commentary on the general tenor of the responses of the mother-infant couple from a succession of different observers.

4 HOME VISITS OF THE DOCTORS

Various record forms and outlines were also tried out for the pediatricians' post-hospital home visits, but as taking notes in the home was usually awkward the pediatricians were instructed to make notes immediately after each visit and to dictate a record on return to the hospital office. They were instructed to note the mother's spontaneous questions and comments, the condition of the home and the presence and relationship of other members of the household, the physical condition of the mother and her attitude in handling or feeding the baby, the physical condition of the baby, to inquire into the baby's behavior patterns of feeding, sleep and elimination, to question the mother in regard to her own habits of eating, sleep, elimination, work and recreation, to inquire into the amount of participation the father takes in the care of the baby, and, finally, to formulate an impression of problems and prognosis. Approximately four visits (one a week) were planned in the immediate post-hospital period prior to the hospital neonatal check-up. Telephone communication from the mother was encouraged and the content of such calls was recorded. Furthermore, in these rooming in families followed by the Visiting Nurse Association, the nurse telephoned to the rooming in office the report of her first few visits in the home, and any questions that she had were taken up with the rooming in pediatrician supervising that particular family. This three-way communication be

tween mother, visiting nurse and rooming-in pediatrician facilitated rapport and continuity of information for the record during the first six weeks of the infant's life.

5. SIX-WEEK CHECK-UP

The six-week check-up is a regular part of the hospital service for mothers and babies of clinic status who were delivered in the hospital. A questionnaire was formulated for this examination to be used by the pediatrician. This reviews the questions of feeding, illness, sleeping difficulties, home situation and mother's condition, in addition to the physical examination of the baby. If the mother wished it, the baby was recommended for follow-up at the appropriate Well Baby Conference.

6. WELL BABY CONFERENCE RECORDS

The Well Baby Conferences are conducted by the Visiting Nurse Association of New Haven and the City Health Department. The mothers and babies are seen once a month during the first year and every six months during the second or third year. The mother is interviewed by the Visiting Nurse and is asked about the baby's feeding, sleep and elimination patterns, and a typical day's diet, and about the problems and questions which she has. The doctor then sees the child and follows through with recommendations and physical examination when indicated. The records on all rooming-in babies who have been seen in any Well Baby Conference have been copied by the Visiting Nurse Association and contributed to the Rooming-In Project record.

7. PSYCHOLOGICAL EVALUATION

Shortly before a rooming in child reaches one year the mother and father are invited to bring the child in for a developmental examination. The Cattell Infant Intelligence Scale is administered. Both the child's behavior and the parents' reactions to the testing situation are carefully noted, and following the formal testing there is a period of conversation about the child and family events during the preceding year. When possible, the psychiatric member of the Study team is present for this part of the interview. At this time, the mother is requested to fill out a questionnaire covering the child's reactions during the preceding year.

8 QUESTIONNAIRE

The topics covered by the questionnaire are as follows

- I Medical history, including dates of illness, doctor's visits, hospitalizations, immunizations
- II Feeding Present food intake weaning from breast to bottle, from bottle to cup, beginning of self feeding mother's impression of the child's appetite, and mother's reaction to the flexible schedule
- III General developmental data during the first year plus unusual occurrences in the family which may have influenced the child's behavior
- IV Habits, discipline, reaction to strangers and frequency of sitters
- V Sleep Place, amount, type, position, problems and changes during the year
- VI Elimination Stools—number, type, regularity of bowel movements, history of constipation or diarrhoea use of suppositories, laxatives or enemas beginning of toilet training
- VII Play Preferred playthings and activities and place of play use of play pen and child's reaction to pen
- VIII Crying Frequency and particular occasions
- IX Emotional responses Occasions for jealousy, fright, anger
- X Mother's detailed reaction to flexible schedule and her opinion of its effect on the child and the household activities
- XI Reactions pertaining especially to the mother The mother's present physical condition, duration of fatigue amount of time available for 'just playing' with the baby Retrospective reaction to rooming in Impression of personality of her child
- XII Reactions pertaining especially to the father Available time for 'just playing' with the baby and his care of the baby Evaluation of the child's personality and retrospective reactions to rooming in

If a family has left the town or for some other reason the mother is not able to bring the child to the office for psychological evaluation, the questionnaire is mailed to those mothers who initially seemed interested in the Rooming In Project Study

The psychological examination at two and three years of age is based on the Merrill Palmer Scale In addition, at three years, the Rorschach Test is administered, and the child is observed in a brief period of doll

play. The two-year-old and the three-year-old questionnaires are similar to the one-year-old questionnaire with appropriate modifications for the age level.

9. SOCIAL WORKER'S HOME VISIT

Home visits are made by the psychiatric social worker near the time of each birthday. Whenever possible, she is introduced to the mother at the conclusion of the psychological evaluation. If it is possible, she arranges to make the home visit at a time when she will have the opportunity both to talk with the mother without interruption and to observe the child and the mother together. The social worker's interest is focused on the home situation and the family interrelationships, and observations of the mother's handling of the child. Because of the social worker's training in interview technique and recording interpersonal relationship data, no special form or schedule was deemed necessary. A similar type of visit is made at about the time of the second and third birthday.

V. CASE REVIEW³

As illustration of the data obtained, one case is reviewed in the following pages. The scheduled interviews and the *one-year questionnaire* are reproduced in the appendix to illustrate methodology of data collection. The record was selected without regard to the content of material, which indeed is less adequate and graphic than that of many other records. It was chosen simply because it was the first case which had Nursery School observations on the child, making it possible to juxtapose and relate two independent sets of data. The record is unlike those of most of the Rooming-In families in its absence of a remembrance of labor interview and in the very unusual lack of data about the father, who remains a shadowy background figure throughout the period of observation. Not only is there no record of contact between pediatricians and the father, but the nurses' notes lack reference to him, and the mother herself is extraordinarily reserved in her reference to her husband. It is recognized that this consistent lack of facts about the father may be more than coincidence or failure to gain information, but it is hoped that these limitations do not detract from the illustrative value of the data which is recorded.

3. The data on this case has been obtained by the pediatric fellows, Dr. James A. Kleeman, Dr. Ruth Svibergson and Dr. Morris A. Wessel; by the psychiatric social worker, Miss Louise C. Wilkin, and by the junior author.

1. INFORMATION FROM PRENATAL INTERVIEWS

Both parents are first generation American of Eastern European stock. They are both in the early thirties. The marriage is mixed Jewish Gentile. The father stopped school at the eighth grade to work and help support his family. He has worked in various unskilled occupations which often take him away from home in the evenings. Mrs. Aye had more education than her husband, having graduated from high school. In addition she had a half year of business school after which she did secretarial work. The father is one of a large family while Mrs. Aye is an only child of hardworking parents and had to learn early to depend on herself. She remembers her childhood as lonely. However, in the family relationship interview she was quick to correct any implied criticism of the way she was brought up, and indicated ambivalence in her evaluation of her parents. Thus she characterized her mother as "abrupt and nervous, won't listen to reason, but has a heart of gold."

The couple had their own home for only a few months after marriage before the husband left for the armed forces. His wife returned to her parental home, and he rejoined her there on his return from the army, allegedly the housing shortage kept them from establishing their own home again. They had planned to start their first baby at this time but Mrs. Aye did not become pregnant for several years. They both wanted children. Because of her own lonely childhood Mrs. Aye wants more than one child but not more than three. Both she and her husband realized that the coming of a child might restrict their activities, but she was prepared to adjust. She intends to give her children more attention and training than she received from her parents. Mrs. Aye intended to nurse, because it would make her feel closer to the baby. She described the fetal movements as "a wonderful feeling."

Aside from the foregoing positive statements, the prenatal interviews were characterized by the appearance of recurring doubts and anxiety which focused principally on nursing and delivery. Her questions indicated need for repeated reassurance. Even in the initial contact in Prenatal Clinic five and one half months before the baby's birth the interviewer found Mrs. Aye "somewhat dubious" about being able to nurse, although she hoped to do so. She opened the second interview a month later with the statement that she was nervous, and questioned whether this would affect her ability to nurse. In the third interview she asked, "How is it possible to keep a baby on schedule when you don't know how much milk he gets?" She admitted that she was afraid of labor, she had heard weird and horrible things from acquaintances. Although wanting rooming in very much she was afraid she wouldn't get in, because it would be too crowded. When seen for the fourth time she again wondered whether she would be able to breast feed although reiterating her wish to do so, and she asked how one could know when the baby is hungry. At her interview six weeks before delivery she said about nursing "It's wonderful to be able to feed the baby with your own milk. It makes you closer to the baby and it would worry me if I couldn't, but lots of my friends have not been able to."

In view of the mother's repeated concern over her ability to feed the baby, one might be inclined at this point to prognosticate difficulty with breast feeding and feeding difficulties for the child but Mrs. Aye's answers to further questions aimed at evaluating the mother's basic attitudes toward child care compel caution in such a prognosis. In the attitude interview, Mrs. Aye stated that a mother should not force her child to eat or hold it to a regular schedule because he might become rebellious and refuse to eat. She does not believe in forcing the child in toilet training but would begin to catch as soon as the child can sit up. She feels that a certain amount of discipline is necessary in order not to let a child walk all over you; however, she does not think the parents should dominate the child or punish without explanation. It will be noted throughout the interviews that the only subject on which Mrs. Aye takes an unequivocal stand is self-demand in feeding which she supports with positive conviction.

2 LABOR AND DELIVERY

Mrs. Aye delivered a boy one day ahead of the expected date of confinement after a seventeen hour labor according to the obstetrician's report without analgesia or anesthesia and with excellent relaxation and excellent acceptance of support and instruction. He described her reaction to birth as the usual euphoria and relief and characterized her as a nervous and worrisome type of individual in view of which he felt she carried out the delivery with good success. The boy was named Alex.

The puerperium was complicated by phlebitis which limited Mrs. Aye's activity, prolonged hospitalization and required bed rest for two weeks at home. She was in Rooming In for eight of her thirteen days in the hospital. She was moved out at the end of the usual lying-in period to make room for another mother.

3 NURSES' AND DOCTORS' NOTES IN ROOMING-IN

The impression of doctors and nurses corresponded with previous impressions of uncertainties and contradiction in Mrs. Aye's reactions. Although she accepted the illness complication she worried because she knew that her mother would be anxious about it. She was able to nurse the baby in spite of the difficulty but she expressed repeated concern about the success of her nursing. Before her milk came in she was worried about its absence and although Alex took hold of the nipple well she was afraid he would be disappointed. Then when the milk came in although Alex nursed well and was quickly satisfied she was skeptical about his getting enough until convinced by measured gains in weight. On the fourth day he was circumcised according to the mother's request and she accepted this calmly until her mother visited and stirred her up. She then became upset and worried about her inability to decide whether the baby's crying indicated hunger or pain from the circumcision. When mother and baby were moved from the Rooming In Unit Alex was put on a schedule and al-

though it was a three hour schedule she resented it because she felt that her hungry baby was not getting fed frequently enough or at the times when he needed to be fed

4 HOME VISITS

Two visits were made in the home after Mrs Aye's discharge from the hospital and prior to the routine hospital neonatal check. The first visit was made two weeks after Mrs Aye went home from the hospital and the second visit was made two weeks later. In addition there are reports of two phone calls from the mother in regard to the baby's progress. During the first two weeks Mrs Aye was extremely discouraged because of the baby's very frequent feedings (about every two hours) and her continued uncertainty as to how much Alex was getting from the breast. She described herself as very tired and impatient and envious of other mothers who had their babies on four hour schedules. However she was unwilling to accept the suggestion of putting her baby on a schedule because she couldn't stand to hear him cry for any length of time. She was wondering whether it might not be a good idea to put the baby on a formula because she couldn't tell how much he was getting from the breast. Her uncertainty was increased by her family who insisted that whenever Alex began to cry he was hungry and should be given something to eat. It was suggested that since she was so worried about the amount of milk the baby was getting from the breast she should weigh him before and after feedings to reassure herself. Mrs Aye did so and was sufficiently reassured to feel that she could accept the frequency of feedings as long as she knew she had enough milk. The time between feedings gradually lengthened until by the time of the second visit feedings were about every three hours and Mrs Aye felt somewhat encouraged and less fatigued. However she continued to bring up various minor problems and seemed somewhat pessimistic about the baby's difficulties.

5 NEONATAL CHECK UP

By the time of the neonatal check when baby Alex was seven and a half weeks old Mrs Aye reported that his feedings were fairly regular at approximately two hour intervals by day and four hour intervals by night that he had begun to sleep from eight thirty to midnight and from one thirty to five in the morning. But she felt that he had an awful lot of gas and this was now her major concern. The mother described the first seven weeks as something hard and expressed herself as dissatisfied with the length of the baby's fussy period which occurred from six to ten A.M. and stated that he ought to sleep longer than he did. The pediatrician felt that Mrs Aye was a very insecure person definitely in need of reassurance and support that she had expected too much from rooming in and was disappointed by the fact that everything was not completely easy from the start.

At this time Mrs Aye was referred to Well Baby Conference. Prior to her

first appointment she telephoned the pediatrician twice with reference to the baby's feeding. She stated that he seemed to be too hungry and complained of his continued frequent feedings during the day. It was recommended that she try giving the baby cereal. He refused this. So the pediatrician suggested offering the baby fruits first, and introducing cereal gradually.

6. WELL BABY CONFERENCE OBSERVATIONS

From the time Alex was eleven weeks old, Mrs. Aye attended Well Baby Conference regularly at appointed times during his first and second years. The pediatric reports consistently indicated him to be a healthy boy with satisfactory nutrition and development. Throughout these visits, Mrs. Aye raised recurrent questions about the child's feeding.

- 11 weeks — No special questions. Breast-fed approximately q. 4 h. one or two bottles per day.
- 16 weeks — Mother concerned because baby "will not take cereal," although he eats strained fruits and vegetables.
- 5 months — Mother still worried because she does not know when baby has enough to eat. Doctor advised mother to discontinue breast feeding. Baby will not take milk from cup, though taking orange juice from cup.
- 5½ months — Mother reports no success in weaning, and continued to breast-feed baby four times a day.
- 6 months — Baby refuses both milk or formula from either cup or bottle. Mother expressed concern that she was trying to wean baby too early for his sake, though doctor had advised her to do so for her own sake.
- 7 months — Baby refuses breast during day, nurses occasionally at night. Refuses formula and orange juice.
- 8 months — Weaning completed. Baby continues to refuse bottle, but will take milk in cereal, and takes solids fairly well.
- 9 months — Mother concerned about baby's not drinking more than 8 ounces of milk. Diet otherwise fine.
- 10 months — Mother worried because baby does not like milk.
- 12 months — Dislikes chopped food; likes strained foods. Beginning to feed self with hands.
- 15 months — Mother considerably upset because baby has not eaten breakfast for past three weeks.
- 18 months — Mother reports she has taken baby to private pediatrician because he has not been eating. Nurse noted coincidence of hot weather and teething.
- 21 months — Mother reports baby eating much better, though still "picky." Drinks from glass at meals with family, and from bottle at naptime and bedtime.

Aside from the mother's preoccupation with feeding no other problems are recorded in the Well Baby Conference notes. The child began to sleep through the night at five months and continued to do so except for a brief period following a fall off a bed and again during teething. The mother began toilet training by catching on the toilet seat at eight months. This proceeded without difficulty so that by eighteen months he was dry through the night and by twenty-one months toilet training was completed.

It is clear from the Well Baby Conference notes that the mother's concern with food plays a considerable part in her relationship to the child. The impression is that although in offering food to the child the mother at no time has evidenced the usual and expected insistence she probably has communicated to the child her expectations about his preferences very clearly. This is most clearly illustrated by the fact that during the weaning period the child reacted first with an exclusive wish for the breast and shortly after turned to a refusal of milk in any form.

In addition to the frequent medical and nursing checks on this child he was seen for developmental evaluation at the Child Study Center three times during the first year at 19, 23 and 31 weeks. These tests all indicated average development. Throughout these examinations much mouthing of objects was noted.

7 PSYCHOLOGICAL EVALUATION AT ONE YEAR

Although mother and child were followed at frequent intervals from the medical/developmental point of view during the first year no intensive evaluation of the child's personality or of the mother-child relationship was attempted until the end of the first year. When seen at this time Mrs. Aye seemed friendly but rather reserved. The impression obtained was that she felt somewhat reticent about any investigation into the past year. Her attitude during the developmental examination was generally self-effacing though she seemed somewhat disappointed that the examination was unsuccessful because Alex, who was teething, was restless and inattentive. Mrs. Aye seemed inconsistent in her own evaluation of the child's development. At one point she said she felt he did things around the home which indicated he was above average but at another that she and her family had felt he was slow in both walking and talking. Mrs. Aye spontaneously expressed concern over the child's insufficient feeding. She spoke of wanting to have another child so Alex could have a playmate but said she hesitated to have one for fear of a repetition of her previous postpartal complication.

Alex made a flexible social response in that he showed no shyness when he was surrounded by several strange people immediately after his entrance into the office but sat in his mother's lap smiling and clapping his hands. He readily accepted being seated at the testing table. The red cubes were placed in front of him whereupon he smiled, cooed and made tentative approaches toward them with his hands. However he did not pick up any of the cubes until Mrs. Aye assured him. It's all right—you can touch them. At one time when

he was given a cube wrapped in tissue paper he held his hands in his lap and whimpered slightly, his manner suggesting that he was quite upset as to whether he should open the object or not. Alex did not show any resentment when objects were taken from him but it was noted that when one article was substituted for another, he showed a pattern of initial shyness and reluctance to touch the new object almost as if he felt that the removal of the previous object had signified that he was not supposed to be handling it. This child seemed rather labile in his emotional expression in that he relaxed easily when something pleased him and showed indications of crying when something did not. He refused two items both of which required the use of teaspoons. Mrs. Aye felt this might relate to the fact that he was just beginning to wish to feed himself and was probably resentful of being fed by others.

This examination was unsatisfactory because Alex was teething and mouthed most of the test materials rather than carrying out any specific tasks with them. Although no precise evaluation could be made, the impression obtained was that the child was developing at an average rate.

8 SOCIAL WORKER'S HOME VISIT

On her home visit the psychiatric social worker found Mrs. Aye friendly but reserved. The child was asleep during the visit so parent-child interplay could not be observed. The mother referred to the same problems as she had during the psychological evaluation with particular emphasis on Alex's refusal to drink sufficient milk. In addition she referred to the complications of living in her parents' home. Her mother could not stand to have the child's toys strewn around the house and Mrs. Aye did not feel free to move her mother's things out of Alex's reach although she was doing most of the household work. Mr. and Mrs. Aye and the baby had only one room and Mrs. Aye tried to keep the baby's toys in this. The impression was she was having to restrict the activities of the child more than she would have in her own home. It was perhaps this restriction which was reflected in Alex's reaction to the test materials during the psychological examination.

9 ONE YEAR QUESTIONNAIRE

The mother's evaluation of the child's first year as obtained through her answering the questionnaire provides some supplementary information to the above. It confirms the mother's preoccupation with feeding noted in both the prenatal and postnatal records, the only area in which she admits dissatisfaction is with the child's feeding. Although stating that she does not feel the child eats enough she has nonetheless adhered to her conviction expressed prenatally that the child should not be forced. At the time of the neonatal check-up Mrs. Aye stated she didn't think the baby slept enough but nowhere in the Well Baby Conference notes is there the slightest indication of a sleep problem nor in the mother's answer to the questionnaire does she express any dissatisfaction with

the baby's sleep habits. However the events which she describes might well constitute a problem for other mothers. The child has no definite bedtime and is often resistant to going to bed. He wakes up during the night several times a week to play or to be fed and is noted to have occasional nightmares. There are indications of a beginning sleep ritual in that he sucks his thumb and must have a piece of towel or wash cloth to hold on going to sleep. As above noted Alex sleeps in his parents' bedroom.

The questionnaire sheds some additional light on the problem of restriction of the child's activities mentioned by the social worker's report of the home visit. The mother notes that he likes to play with a drawer of silver in the toilet bowl and with towels in a drawer none of which is allowed him.

The questionnaire indicates the mother's genuine acceptance of self-demand principles. She characterizes Alex as being a very happy and contented baby and attributes this to the fact that he has not been forced to do things he was not ready to do.

SCREENING AND FIRST PRENATAL INTERVIEW FOR SECOND PREGNANCY

When Alex was twenty months old Mrs. Aye was seen in Prenatal Clinic where she had registered for her second pregnancy and for rooming in. She was five months pregnant. She said she had not planned to have another baby for another year. Her back ached. She felt tired and the housework seemed too much for her. She was still living with her parents but she knew she was going to have to move. Her mother reproached her with selfishness, thinking only of herself and having babies and not considering her parents. With this uncomfortable family situation with the prospect of moving ahead of her and a somewhat dreaded childbirth because of her previous complications she felt confused and discouraged.

Three months later when Alex was almost twenty-three months old she was interviewed again and gave more detailed information than usual about Alex and the home situation. She stated she wants to nurse the next baby but maybe not so long. Her mother got awful provoked because she took so long nursing Alex—sometimes three-quarters of an hour. (It is noteworthy that although Mrs. Aye at this time had found a cheaper rent which she intended to take she continued to think in terms of shaping her actions in response to her mother's criticisms.) She alluded to the complicated home situation in which she is responsible for doing the housework, keeping the house in order, cooking the meals and everything else.

She stated it was wonderful to have Alex at Nursery School both for her sake and for his. She finds it relaxing on the mornings he is away. When he comes home from Nursery School he eats especially well and goes right to bed for a nap. Mrs. Aye reported that he was growing up, that he was talking more and that he had learned to play with other children in the Nursery School and with his toys alone at home. She then stressed another difficult aspect of the home situa-

tion—Alex puts his toys all over, she cannot bend down and pick them up, her mother can't stand having them all over the house. Alex, she stated, was refusing to eat, but immediately corrected herself by adding, 'He eats all right when we are alone, but this business of having so many people around upsets things when I try to be a little bit firm, the others pick on me, or pick Alex up. When I put him to bed and try to leave him alone, or lie down with him quietly, then others in the family interfere . . . He knows what I mean when I tell him 'No' but the others tell him to go ahead. I wonder if my nervousness is doing things to Alex . . . I feel so much in a fog all the time."

The foregoing material summarizes the prenatal data and first twenty three months of the postnatal data of a Rooming In Project record. It has been presented *chronologically as an illustration of methodology in collecting parent child relationship data* designed to throw light on the questions: What is the mother's and child's response to flexible schedule, and does the knowledge obtained about the mother's attitudes contribute to our understanding of the child's developmental characteristics? Before attempting to summarize and correlate the information about mother and child, further data about the child from his nursery school record will be presented. The authors are indebted to Dr. Milton J. E. Senn, Director of the Child Study Center, for making available the Nursery School data and to Dr. Ernst Kris for contributing the section on 'Initial observations in Nursery School.'

ADMISSION TO NURSERY SCHOOL

At twenty-one months Alex was entered as the youngest child in Nursery School because his mother wanted him to have companionship. At this time the outstanding characteristics of the child were noted to be oral activity and ritualistic behavior. The rituals at home included putting his toys in and out of the bath, squeezing out the wash cloth and pulling out the stopper, lining up all his mother's shoes in the kitchen and taking out the laces, unrolling all his father's socks in the living room, going through the motions of tying the shoe laces of all the adults in the household. He had to have everything in his room in order, and would not let others touch his toys. He was distressed and cried if he was not allowed to follow out these patterns. At every mealtime he had to have the family forks lined up and refused to eat if they were not in place.

At the time of the entrance developmental examination, he was noted to be constantly chewing or sucking on rings, pegs, blocks or other objects as well as on his fingers.

INITIAL OBSERVATIONS IN NURSERY SCHOOL

Observation of the child was carried out by a variety of observers in the Nursery School. These observers were in part nursery teachers, in part observers who under the direction of Dr. Katherine Wolf, took a record of behavior over short periods of time, and in part casual observers who took regular notes. On

two occasions the child was filmed without his knowledge, as a check on the observations. While the data have not been worked over in detail, the following summary of impressions can be given.

The child, who was the youngest in a group of two year olds, adapted slowly to the new environment and in his process of adaptation showed a number of traits not shared by any of the other children, nor by children of his initial age who later joined the group. He was more inclined than any other child to stay on the periphery, aloof from the group. He did not show a great need for the nursery teacher, and he had a marked inclination to substitute inanimate objects for animate ones. On the second day in the nursery school, the mother remained out of sight and he did not look for her, but throughout the morning he carried his hat, rolled up under his arm. The difficulties in establishing contact with the group refer to the completed contact. Alex was constantly engaged in looking at other children and their activity. This was not only noted by the observers, but most clearly shown in the film record. The impression was that he waited until a situation arose in which he would be perfectly safe to join in, for instance, when he could help another child put on a piece of clothing, or when he could pick up an object which had been dropped by some other child. When ever contact was established there were certain difficulties in the regulation of its intensity. When he gradually established a closer relationship to a little girl, the way he patted her remained ambiguous. The nursery teacher had to say, "Alex was patting you," because the difference between patting and hitting could not be clearly established. In generalizing one may say Alex was wavering between the two extremes of aggressive and withdrawn behavior.

Alex was observed to mouth objects frequently. His mouthing did not appear to be object directed. Very rarely was he seen to suck his thumb but any new object, toy or tool, was for a very short period inserted into the mouth as if that was a way of becoming familiar. One might say the mouthing served to establish contact, not to retain it. In contrast to the tentative character of this approach, the other extreme of Alex' behavior was characterized by wildness. This was stimulated sometimes on days when only a few children were present instead of ten or eleven, and particularly in playing with the older, more sturdy boys with whom he behaved like an equal. On such occasions he was seen to become aggressive, and to attack little girls. In this attack there was expressed extreme possessiveness in an erotic sense, but also aggressiveness in an unmistakable and very direct sense. For instance, in stepping on a little girl's hands these two extremes of behavior did not occur on any one day, but occurred in phases. Amongst observers the question 'How is Alex today?' was frequently answered by, "This is once more one of his quiet days."

DISCUSSION

In reviewing the data from the Rooming In Project record, together with data from the Nursery School record, there are certain outstanding features of the home situation, of the mother's attitudes, and of the child's

characteristics in his first and second year which appear to be interrelated

The two items that stand out most clearly in the mother's attitude in the care of her child is her concern that he will not get enough to eat, and her wish to avoid loneliness for him. She is able to verbalize the fact that she wants him to have companionship, because she herself suffered from loneliness. There is nowhere an explicit statement to explain her concern over the feeding situation. She does however state that she intends to give her children more time and attention than she received from her parents, so it is reasonable to assume that her feeling of need for attention may have found an oral expression.

These two concerns of the mother are consistent trends in a record otherwise characterized by uncertainty, inconsistencies and ambivalence. This ambivalence is most evident in her relationship to her mother both in her childhood memories and in her present attitude. She has continued to live with her parents, although claiming she has wanted to move for a long time. Because she lives in her mother's home, she has found it impossible, on the one hand, to guide Alex in accord with her beliefs because of her mother's impatient and overpermissive interference, and on the other hand, it has been impossible to carry out her conviction that the child should not be rigidly restricted in his exploratory activities and in his use of playthings, because her mother cannot stand disorder and mess. It is this necessity to inhibit his exploratory activity against her principles which constitutes the third major point in the mother's record.

The early information about the child is dominated by Mrs. Aye's report of a series of transitory refusals of food. The child maintained good health throughout his first year and gained satisfactorily, so these refusals cannot be said to constitute a feeding problem, except in the mother's mind. Even if it might be assumed that the child's refusals were a reflection of the mother's wish (unconscious) to continue breast feeding or prolong her child's infancy, it is nonetheless striking that Mrs. Aye was able to adhere to her conviction of "ad lib" and refrain from any attempt to force her child. According to the record she practiced ad lib or flexible schedule without reserve in regard to feeding and sleeping. And she never complained throughout the period of observation of a sleeping problem with Alex. As elsewhere noted, however, the child's late bedtimes and his irregular wakings during the night might have constituted a problem for other mothers. There is no hint in the record of an elimination problem. Aside from the child's refusal of water, cereal, milk and breakfast, one after the other, there is no indication of any behavior deviation until the time of the one-year psychological evaluation.

During the psychological examination the most striking aspect of

Alex' behavior was his apparent anxiety about touching the various test materials, even with the permission of his mother. It seems justifiable to interpret this tentative approach to objects as a response to the restrictions imposed on him in the home. Other noteworthy characteristics at this time were indiscriminate mouthing of objects and emotional lability.

During the first few weeks at nursery school Alex stood out from the group because of his aloofness and difficulty in establishing a relationship with the other children or the teachers. He showed little or no need for the teacher, and his contact with the children developed from the initial reaction of merely watching from the periphery to a phase marked by alternation of aloofness with aggressive episodes. In evaluating the meaning of this behavior it must be kept in mind that up to this point Alex had had almost no contact with other children and had been raised in a household of four adults. Furthermore, he was the youngest child in the group by one to four and a half months. Nevertheless, the observers felt that his deviation from the other children could not be attributed only to these facts. When the two records are considered together, a striking parallel is apparent between the mother's loneliness and ambivalence in response to others and the child's aloofness and variations in intensity of contact.

The contact disturbance with aggressive episodes leads one to wonder with what inconsistency the mother and other adults in the household have treated the child and what aggressive outbursts he has witnessed in the home. It is regrettable that the data is lacking on these points, and that the influence of the father can in no way be evaluated because so little is known about him.

Two other characteristic aspects of the child's behavior are less clear in their interpretation than his tentative approach to objects and his aloofness to people, namely, mouthing of objects and rituals. One can speculate that mouthing, in addition to offering oral satisfaction, serves as a method of gaining contact as a substitute for the more active tactual exploration which so often has been denied him. (It will be remembered that the child has always been offered feeding promptly in response to crying.) The most direct interpretation of the rituals which Alex developed between his first and second years is that they represent a reaction to the need for order, which has been imposed on him in the home, but they may well have a deeper meaning.

The record comes to a close at a crucial point in the child's life just before the birth of a sibling and a move to a new home away from the grandparents. It is difficult to predict what Alex' reaction will be to these events, but one can assume that his adaptation to these two great changes in his life will alter the patterns of behavior thus far observed.

SUMMARY AND CONCLUSIONS

In the above discussion, it has been found possible to relate certain observed aspects of a little child's behavior and certain attitudes of the mother in taking care of him, documented in records of interviews with the mother and observations of the home situation. If in this correlation the authors have seemed to stress the effect of situational factors on the child's behavior, it is not that they discount hereditary influences, but rather that environmental factors are more readily observed and described. Furthermore, a study of the environmental factors permits not only a tangible evaluation of the situation but offers an approach to the understanding of the personality of the parents since the latter determines in some measure the selection of the environment. In the case of Family Aye, the mother's need to remain in her parental home determined a complex and frustrating situation for the child.

The above case review suggests need for the evaluation of two factors in this type of parent-child relationship study: (1) the degree of importance of environmental events on the child's personality development; (2) the extent to which a child's behavior can be predicted from knowledge of the parental, especially maternal attitude. The case of Alex Aye is one which shows clearly the influence of both situational factors and maternal attitudes on the child's behavior. Although these influences cannot be quantified, it would seem that the methodology for collection of data described above is a fruitful approach to the recognition of relationship between maternal attitudes in child care practices and the child's behavior.

APPENDIX⁴PEDIATRICIAN'S SCREENING INTERVIEW OF PREGNANT WOMEN FOR
ROOMING-IN STUDYNAME *AYE, Evelyn* AGE *31*

EXPECTED DATE OF CONFINEMENT _____ UNIT No. _____

HUSBAND'S NAME *Max* OBSTETRICIAN *Clinic* PEDIATRICIAN *Clinic*

ADDRESS _____

HOW LONG DO YOU PLAN TO LIVE IN NEW HAVEN? _____

GRAVIDA *I* PARA *O* ABORTUS *O* DEATHS *O*SEROLOGY *Negative* RH *Positive* COLOR *White* RELIGION (DENOM) _____

4 The mother's verbatim answers to the interview questions are quoted in *italic*; information obtained but not reproduced is indicated by a dash; questions which were not asked are left blank. Data reproduced with permission of mother.

BIRTHPLACE (Your own) *Massachusetts*

| | |
|---------------|-----------------|
| Your Mother's | } <i>Russia</i> |
| Your MaGM | |
| Your MaGF | |

| | |
|---------------|-----------------|
| Your Father's | } <i>Russia</i> |
| Your PaGM | |
| Your PaGF | |

OCCUPATION OF YOUR FATHER *House painter*YOUR HUSBAND'S AGE *32* COLOR *White* RELIGION (DENOM) _____BIRTHPLACE (Husband) *New York*

| | |
|------------|-------------------|
| His Mother | } <i>Bulgaria</i> |
| His MaGM | |
| His MaGF | |

| | |
|------------|------------------|
| His Father | } <i>Unknown</i> |
| His PaGM | |
| His PaGF | |

OCCUPATION OF YOUR HUSBAND'S FATHER *Unknown*Where did you go to school? _____ How far? *High School Graduate*
(Year of graduation) *Secretarial School—one year*Your Husband's School _____ How far? *Grammar School Graduate*
(Year of graduation)What kind of work have you done? (Include present occupation) *Office work*What is your husband's work? (Past and present) *Odd jobs, helps father in law*When were you married? (*Six years prior to expected date of confinement*)
(Verbatim answer, and ask date if not given)How do you feel about having this baby? *Anxious to have baby*Was the baby planned or did it just come? *Planned*Are you planning to nurse or bottle feed the baby? *I hope to nurse*

If accommodations under both the Separate Nursery and the Rooming In Plans are available at the time you deliver, which would you prefer? *Rooming in*
Why? *I've heard about it It interested me I want to nurse, and I think it will help me Until recently, people weren't interested in nursing You be come accustomed to the baby If I had another, I wouldn't care so much*
(Pediatrician describes Rooming In Any change in patient's preference to be noted under REMARKS)

Where did you hear of it? *Through a nurse who works here, and from friends who have had it*Is this person a good Rooming In or Control Candidate? *A fairly good candidate*
If not give reasons why (Specify reasons in detail)EVALUATION AND REMARKS *Very much wants to nurse if able, and would like help—i.e., she is somewhat dubious about being able to nurse*DATE *4th Month —* INTERVIEWER *A.K*

ANTENATAL FIRST INTERVIEW WITH PEDIATRICIAN

NAME *Aye* DATE *5th Month* INTERVIEWER *A.K*How are you getting along? *Quite nervous, otherwise feeling fine*

Last time we talked about the idea of having the baby with you as compared with having it in the Nursery, and you said you might be interested How

do you feel about it now? *"I think it is a very good idea, but how can you keep a baby on schedule when you don't know how much milk he gets?"*

Have you talked to your family about it? To your husband?

What did they think?

There are some questions we are asking all mothers who are interested in Rooming In. You may have been asked some of these questions before, but we hope you won't mind answering them again. If you yourself have any questions now, or at any time, please feel free to ask them. If any of our questions are not clear, please don't hesitate to tell us.

PREVIOUS PREGNANCIES (Age, sex, baby's health, mother's condition during pregnancy, feeding, reasons for nursing, reasons for bottle feeding, reasons for and time of discontinuing breast)

- 1.
- 2.
- 3.
- 4.

Are you going to nurse your baby? *Yes* Why? *"One hears of it from doctors and books. There's a sign in the hall that faces you as you come in. There's less colic with breast fed babies."*

What does your husband think about nursing? *"He's in favor of it"*

FAMILY HISTORY

Is your mother living? *Yes* Where? _____

Is your father living? *Yes* Where? _____

If not living date of death? Cause?

How many brothers and sisters do you have? (List them in order of age) *None*

Did your mother lose any children?

Is your mother in law living? *Yes* Where? _____

Is your father in law living? *No* Where? _____

If not living date of death? Cause?

How many brothers and sisters does your husband have? (List in order of age)

Did your mother in law lose any children?

PRESENT PREGNANCY

Did your mother nurse you? *Yes*

Did she nurse your brothers and sisters?

What advice has she given you about nursing? *None*

(Do you know what her attitude toward nursing is?)

Did your mother in law nurse her children?

What advice has she given you about nursing? *"None—I don't see her very often"*

(Do you know what her attitude toward nursing is?)

What are you doing to prepare yourself for nursing? *"Cleaning breasts Nipples are O.K., I was told about cocoa butter"*

Do you want a boy or girl? *"It doesn't matter, as long as it isn't twins"*

Does your husband want a boy or a girl? *"No preference Mothers in law have preferences"*

Have you chosen a name for a girl? *No*
After whom?

Have you chosen a name for a boy? *No*
After whom?

Did you plan to have your baby now? *Yes*

How have you felt so far during pregnancy? *Fine, except for frequent headaches*

How do you feel about visitors while you are in the hospital? *"That's all right"*
(EXPLAIN visiting rules after obtaining this comment)

Would this visiting arrangement have any effect on your preference for having the baby with you? *No*

ANXIETY RATING SCALE

| | |
|-----------------------------|-------------------------------|
| <i>Anxiety</i> | <i>Verbalization</i> |
| <i>Marked</i> | <i>Very verbose</i> |
| <i>✓ Moderately anxious</i> | <i>Moderately verbose</i> |
| <i>Within normal limits</i> | <i>✓ Within normal limits</i> |
| <i>No apparent anxiety</i> | <i>Unresponsive</i> |

REMARKS *The mother started out the interview with the statement she is quite nervous, and asked if that would affect her nursing. She is quite reticent about talking about her husband's interests. Spontaneously said that she does not go to church. She is quite apprehensive, not very secure. Inquired about her baby's lack of movement. Is interested in Natural Childbirth and the Read Method.*

SECOND ANTENATAL INTERVIEW WITH PEDIATRICIAN

NAME *Aye* DATE *7th Month* INTERVIEWER *B.S*

How have you been feeling since we talked last time? *Well*

Do you have any questions? *"I am worried about whether I will be able to breast feed. How do you know when the baby is hungry?"*

Did you talk over any of the things with your husband that we talked about? *What did he say? "Yes. He thinks Rooming in is wonderful"*

FOR THOSE BABIES THAT ARE PLANNED Why did you plan to have the baby now? *"We've been trying for a long time. I don't think a marriage is successful without a baby"*

Did you and your husband feel the same way about having the baby at this time? *Yes*

FOR PRIMIPARAS WITH BABIES UNPLANNED How do you feel about having the baby at this time?

How does your husband feel about having the baby at this time?

FOR MULTIPARAS WITH BABIES UNPLANNED

Although you did not plan this child at this particular time, did you want another child at some time in the future?

When would you have chosen to have it?

Why at that time?

FAMILY PLANNING

How many children do you plan to have? *"If no financial worries, three or four
 Couldn't cope with more"*

How long do you want to wait between children? Why?

Before marriage did you and your husband discuss the question of having children? *"Yes, but we didn't talk much We knew we wanted children"*

If so, did you come to any conclusion then when you wanted to have your first baby? *"Yes, when my husband got back from the service I didn't want to wait too long—I'd like to grow up with my children But the war postponed things"*

Before marriage, how many children did you plan to have? *"Three"* Why? *"I don't think we could care for more I won't stop with one An only child loses too much"*

Before marriage, how long did you want to wait between children? Why? *"It all depends on how I feel and on finances"*

Are there any things that you and your husband wanted to do together, that you won't be able to do now that your baby is on the way? *No*

Are there any things that you yourself wanted to do, that you won't be able to do now that your baby is on the way? *No*

How much do you think a baby will restrict your usual activities? *"When you prepare for a baby, you have to do it wholeheartedly and not give it to some one else to care for"*

Are you going to have anybody to help you when you come home from the hospital?

(If OTHER CHILDREN) Who will take care of your children while you are in the hospital?

Do you own your own home? *No*

If not, where are you living? *"With my parents"*

How many rooms do you have? *"Four"*

Who else is living with you? *"Mother and Dad"*

Are you satisfied with your living conditions? *Yes*

Do you feel you can afford to have a baby at this time? *Yes*

Do you have equipment ready for the baby? *"No—I plan to go to classes first"*

Have you gone to VNA Mothers' Classes? *No*

Any particular reason why not? *"I am still working—but I plan to call them and go"*

Do you smoke? *No* If so, do you consider yourself a heavy, moderate or light smoker?

How have you felt so far during pregnancy? *"Pretty well, except for backache lately when tired"*

Are there any things which have worried you during your pregnancy? *"Not now, but I have been worried about delivery"*

Is pregnancy anything like what you thought it was going to be? *"I never really thought about it"*

How is this pregnancy as compared with your previous pregnancy(ies)?

Has your husband been as understanding toward you during pregnancy as you would have liked? *"Yes, he's been wonderful"*

What are the kinds of things other people have told you to expect during pregnancy? *"You're just in for something horrible"*

ANXIETY

Marked / Moderate anxiety Within normal limits No apparent anxiety

VERBALIZATION

Very verbose Moderately verbose / Within normal limits Unresponsive

REMARKS

Mother repeated previous questions about her uncertainty about breast feeding and chances of getting into Rooming in

THIRD ANTENATAL INTERVIEW WITH PEDIATRICIANS

NAME *Aye* DATE *8th Month* INTERVIEWER *B S*

How have you been since we talked last time?

Are there any problems which have arisen? *"I still have backaches Hungry"*

Are there any questions you have to ask since we talked last time? *"Where do I come when in labor? What do I bring?" Asked about breast care, about whether it is all right for her to paint furniture, about circumcision if the baby is a boy*

What have you read about babies—about having babies or taking care of babies? *"Grantley Dick Read, pamphlets from the clinic, PARENTS' MAGAZINE"*

We have found in the past that mothers and fathers have different kinds of dreams at different times during pregnancy We are very much interested in seeing if there is a relationship between the kind of dream and the period of pregnancy

What have your dreams been? *"I dream less now"*

Many mothers tell us there are certain dreams they have more than once What has been your experience? *"I haven't had any"*

What have you dreamed about the baby? *"I dreamt once or twice around the middle of pregnancy about the baby I don't remember well It was a girl, and newborn I also dreamed of other people having babies"*

Do you think you are going to have a boy or a girl? *No idea (Why?)*

What have you noticed about your baby's movements? *"He kicks quite a lot There's a steady pounding down further sometimes He kicks most when I'm still"*

How do you feel when the baby moves? *"It's a wonderful feeling You can't imagine anything moving in you that way"*

How do you think nursing affects the mother? (If answered in terms of effect on baby repeat question) *"It makes her closer to the baby I don't know how to put it into words It gives her a different attitude toward the baby It's wonderful to be able to feed the baby with your own milk"*

How do you think nursing affected your other children?

Did you enjoy nursing your other child (children)?

Have you ever had any doubts about nursing at any time? *"Lots of friends couldn't. It would worry me if I couldn't."*

Does your husband feel as strongly about nursing as you do? *Yes.*

For PRIMIPARAS: What have you heard about labor? *"Most weird stories. Always bad. One of my friends said she wouldn't go through it again."*

For MULTIPARAS: What were your previous labors like?

What were your mother's labors like?

Did she tell you about your own birth?

What were you told?

Have you any worries about labor or delivery? *"I'm a little nervous. The stories are so awful."*

What experience have you had with children? *"I haven't had any. I'm an only child."*

ANXIETY RATING SCALE

| | |
|----------------------|----------------------|
| Anxiety | Verbalization |
| Marked | Very verbose |
| ✓ Moderate | ✓ Moderately verbose |
| Within normal limits | Within normal limits |
| No apparent anxiety | Unresponsive |

REMARKS:

Has read Read's book and wants to reread it and speak to the obstetrical doctors at next visit. She is afraid of labor, and is going to talk with one of her friends who had a successful Read delivery. She wants Rooming-in a lot, but does not think she will get in because it will be too crowded.

MOTHER'S "ATTITUDE" INTERVIEW WITH PEDIATRICIAN

NAME: *AYE*

DATE: *9th Month*

INTERVIEWER: *B.S.*

How are you feeling?

We find that mothers have different viewpoints about how to handle certain of the baby's activities during the first year or two—such activities as eating, sleeping and toilet training. How do you think they should be handled?

Feeding? *"You should not force the child. A child knows how much it needs. I've seen mothers aggravated, and then the child gets aggravated and won't eat."*

Do you think a baby should be fed on a regular schedule? *No. Why? "Sometimes the baby is sleeping and doesn't want to eat. When the baby is hungry, he will let you know."*

Sleeping? *"If a child plays a lot, he will go to sleep early. Babies sleep a lot. I don't know much about their habits."*

Toilet training? *"I won't force it. I think when a baby is able to sit up is time to start 'catching'."*

Some people think when a baby cries you should pick it up—others think that this will tend to spoil a child. What do you think? *"I would see if the baby is wet or hungry. Sometimes the baby wants affection or is lonesome. Just wouldn't make a habit of it every few minutes."*

What things do you think are responsible for the spoiling of children? *'Showing too much affection and always giving the baby what it wants Picking it up all the time if they cry and walking the floor'*

In what way if any, would you discipline your child during the first two years? *'There should be a certain amount—not let the child walk all over you But not be so domineering that you make life all don'ts' Makes the child nervous You can bring out a point without scolding You do sometimes have to punish, but after that you should give an explanation*

What do you think a child has to be disciplined for in the first two years?

In what way will you bring up your children differently from the way you were brought up? *'I think I'd give the child more attention and training than my parents did My parents were foreigners and couldn't help me much My husband and I feel very much the same way about all these things'*

ATTITUDE TOWARD PREVIOUS CHILDREN

Are you planning to do anything differently in bringing up this child than you did with your other children? If yes why?

Have your children (child) asked you questions about where babies come from or any other questions about sex?

What have you told them?

Do you feel you have as much time to really enjoy your children as you would like?

What is your child's (children's) attitude toward your husband?

Do you think there is any difference in bringing up little boys or little girls?

What have been your main problems in bringing up your children?

Have there been any problems in school?

(State school data if there are children of school age)

MOTHER'S FAMILY RELATIONSHIP INTERVIEW

NAME Aye

DATE 9th Month

INTERVIEWER B.S

How are you feeling?

In your opinion how do you think a person's childhood affects the rest of his life? *'It starts its life off The child formulates its idea and really looks towards the rest of life It gets general beliefs in the early age*

What was your childhood like? *'I am an only child My father and mother both worked I had to take a lot of the housework over—I couldn't let mother come home and do the housework My father and mother are very liberal and have helped me a lot'*

How did it affect you? *'It certainly has started me off in life—given me many of my views I never regretted the way they brought me up—it was the right thing'*

What things do you remember most vividly about your childhood?

What do you consider, had the greatest influence on you in your childhood? *Nothing, particular Just everyday living'*

Were you closer to your mother or father? *'Father'* Why? *'Mother was more*

abrupt and less understanding Father never hit me—mother was always the one She was rarely home weekends—she'd be working"

How did you get along with your brothers and sisters?

Would you say your parents were lenient or strict with their children? *"They weren't lenient, but weren't too strict Would put their foot down if they knew I was doing something that was not right"*

Now, this is a difficult question to answer, but can you describe what sort of a person your mother is (was)? *"Abrupt, nervous, won't listen to reason Has a heart of gold, though"*

Your father? *"Easygoing The exact opposite of mother"*

What did you learn about sex from your parents? *"Not a thing"*

What did you learn from other sources (people, books, lectures etc.)? *"Learned from the girls I went around with When I started menstruating, mother told me to go to someone else I wasn't too surprised about it, because I had heard about it from girls Got the 'wrong side' of it"*

REMEMBRANCES OF LABOR

Baby's Name_____

Day, Date Time of Birth_____

Mother's Name_____

Date_____ Interviewer_____

What was your action when your labor first began?

What did you think about in the labor room?

What were some of the things that went through your mind in the delivery room?

What were your first thoughts after the birth of the baby?

How did you feel when they told you you had a boy (or a girl)?

What did you think of the baby when you first saw him (or her)?

Was the birth of the baby anything like you expected?

Do you think things could have been handled any differently during your labor?

What did you mind most about labor?

What did you like most about labor?

What did you mind most about delivery?

What did you like most about delivery?

What helped you most in your labor and delivery?

If you have another baby, would you like it the same way?

NEONATAL CLINIC

Baby's Last Name *Aye*

First Name *Alex*

Temp 99 Ht. 21½" Wt 10½ lbs Unit No

Father present? *No—grandmother present*

How have you been getting along? *At night sleeps 8.30—12.00 and 1.30—8.00, but still every 2 hrs during the day Still seems to get those gas pains—what can we do?"*

Feeding

Breast

Are you still nursing? *Yes* If not, when stopped? *—*

Why did you stop?

Both breasts each feeding? *Yes* For how long per feeding? *15 and 10 minutes*

How often formula? *2 3 times per day* How much? *Most 2 ounces*

Formula *Evaporated Milk 5 ounces, Water 8 ounces, Sugar 1 tablespoon*

How made?

How much per feeding?

How many times a day does *Alex* eat? Approximately when? *5 00, 8 00, 10 00 A.M., 12-1 00, 3 00, 5-6 00 P.M., formula 7-8, 12 00 or 12 30 P.M.*

Any regularity? *Fairly regular*

How did you decide on these hours? *He decides If I see it's a little too close to last feeding, will give him water (1 hour)*

How do you know when *Alex* is hungry? *He screams If I pick him up and he stops, I think not Also goes at fists*

Vitamin C Intake—*Stopped because of pain and loose bowel movements*

How given?

Vitamin A & D Intake—*7 drops oleum per comorph* How given?

Bowel Movements *1 to 3 per day* Description *"Good but slightly watery on outskirts"*

Diaper rash *No*

Gas or Colic *"Lots of gas—an awful lot"*

Illnesses? *"Just a stuffy nose since discharge"*

How much water does *Alex* take? *'Not much'*

Any vomiting or "spitting up?" *Did today*

How about "bubbling?" *"Better"*

Are you satisfied with the way *Alex* feeds? *"Oh yes,—feel much better"*

How many "rough nights" or "rough days" have you had?

What happened? *"Used to until 5 days ago—wake every 2 hours"*

Why?

Does *Alex* have any special fussy periods? *"Morning 6 00 A.M.—10 00 A.M. Has lot of gas this time, too"*

Does *Alex* cry much? *"Just with gas pains and hunger"*

Circumcision? *Yes* When? *In hospital* Why? *"Thought best for him, and his band's family believe in it"*

How does *Alex* sleep? *On stomach "I'm not satisfied—think he ought to sleep longer than he does"*

Development

Holds head up when prone—

Started—

Smiles—*Yes*

Started—*One week*

Vocalizing—*Yes*

Started—*One week*

Following moving objects with eyes—*No*

How is rest of family? *"Fine"*

How much help do you have in caring for *Alex*? *Mother helps during day*

How do you feel yourself? *Much better Sort of tired, no chance to sleep during day Back much better*

Have these first 6 weeks been what you expected? *'I don't know—were something hard'*

Any other questions? *Alex still has a stuffy nose with phlegm in throat When can I take him out?'*

Physical Examination *A well developed, slightly plump, white baby boy Moderately fussy, alert Posture good*

Skin Intact Head 38.5 cm symmetrical Anterior fontanelle 2 cm

Ears, Eyes, Nose, Throat Negative

Lungs clear to P & A Heart regular without murmurs

Abdomen soft Liver and spleen not felt No masses

Genitalia Male, circumcised

Extremities Not remarkable

(Please make special note of personality, skin turgor, head circumference, foreskin posture, Landau reflex)

IMPRESSION WELL BABY

Rx *Pabulum primum* TO WELL BABY CONFERENCE { *Yes—At N.H.H. R.I.*
No Signed B.S.

ONE YEAR QUESTIONNAIRE

PARENTS NAME AYE Evelyn and Max

DATE

ADDRESS

CHILD'S NAME Alex

BIRTHDAY

CHILD'S HEIGHT AND WEIGHT AT OR CLOSE TO 1 YEAR

NAMES AND BIRTHDATES OF BROTHERS AND SISTERS

| | |
|--------|---|
| 1 None | 4 |
| 2 | 5 |
| 3 | 6 |

LATEST SNAPSHOT IF EXTRA PRINT AVAILABLE (PASTE)

I List illnesses (including colds) injuries or accidents with dates noting severity and duration

Running nose—December—lasted 2 days

Running nose—September—lasted 2 days

Has fallen out of the carriage, bed, etc

Has it been necessary to call a doctor? List reason for call date and whether office or home visit *Haven't called doctor as yet*

List hospitalizations if any *None*

List immunizations and state by whom *Small pox*

Whooping cough

In Well Baby Conference

Diphtheria Toxoid

Tetanus Toxoid

(For boy babies) If circumcised when and why? *Circumcised—done in the hospital about the third or fourth day after birth—I insisted that it be done because I didn't want it done when he would be older and under stood more I've seen it done and the bad effects it had on the boys—and also done for the health aspect*

II. Describe the child's appetite in your own words *His appetite has been up and down When he was nursing it seems he was always hungry, but as I got on to baby foods it was a gradual process until he was accustomed to it He eats pretty well unless something is bothering him It takes him a long time to become accustomed to new foods*

Do you think the child eats as much as he should? *To me it seems he doesn't eat much, but I have let him decide how much he wants and I don't force more*

| | | |
|---------------------------------------|------------|--------------------------------------|
| What type of food does the child eat? | Started at | Stopped at |
| Baby food | 3rd month | [Still using but gradually stopping] |
| Chopped food | 11th month | |
| Same as rest of family | | |

Does the child use a cup or bottle? *Cup and bottle If cup when begin to use? I have to hold the cup because he turns it upside down—started to use it in 9th month*

What foods does he like best? *Desserts—oranges—apples—hard cr st of bread*

What foods does he like least? *Seems to eat everything I give him*

What foods does he refuse? *Beets*

Why do you think the child doesn't like these foods? *Probably the texture*

What do you do when the child refuses foods? *Take it away and forget about it for a week—if still refuses it, leave it alone altogether*

When did the child stop spitting up? *If I remember correctly, hadn't done it except if bubbled—or overfed or during his teething period*

Has the child vomited? *Not that I remember I may be getting spitting and vomiting mixed up but when he has brought up food it hasn't been much*

Is the child on three meals a day? *Yes*

When did this start? *Sixth or seventh month*

Does the child eat between meals? *Has juice—bread or piece of apple*

| | | |
|---------------------------|-------|-------------|
| Where does the child eat? | Alone | With family |
| Breakfast | ✓ | |
| Lunch | ✓ | |
| Supper | ✓ | |

Type of chair and table *High chair and table combined*

When did the child first make attempts to feed himself?

Describe

Hasn't tried as yet—have tried to put the plate before him several times but he turns the plate upside down, and when I put some food on his table he picks it up by his fingers and then smears it all over

To what extent does he feed himself now? *Drinks water from bottle himself and eats oranges—skin and all. He is very interested in playing with blocks and books that he just can't be bothered with food—he probably thinks it's something to play with.*

Who feeds him? *Mother*

For how long was the child completely breast fed? *7 months.*

When were bottles added? Explain: *In the 7th month he stopped nursing himself and I tried to give him bottles but he refused it—in fact now he will only take milk at bedtime—in fact it's been this way since he had stopped nursing I'm only sorry I didn't give him at least one bottle a day because when I stopped nursing he just refused the bottle except for water and juice*

When did you stop breast feeding entirely, and how did this come about? *7th month—refused it himself*

How do you feel about nursing your next baby? *I would nurse my next baby again but I would also give one bottle of milk a day so he would know that milk also can be gotten from a bottle It's a mystery to me—he would take water and juice from a bottle but not milk I tried to fool him but it wouldn't work*

To what extent are you still following the ad lib (self-demand) way of feeding? *I still leave his feeding up to him—he has a habit of sucking on his hand when he's hungry It's between 4 and 5 hours between each feeding And he gets up at night quite often to be fed milk*

III Describe general development during the first year.

Sat unsupported at 6 mo

Crept at 9 mo,

Pulled self to standing position 11 mo,

Stands alone 12 mo,

Walks alone 13 mo,

Climbs stairs — mo, has there been opportunity to climb? *Yes*

Said first word 7 mo First word was *Dada*

Said second word 7 mo Second word was *Ma Ma*

List other words and objects named and order of appearance

Kutty meaning Kitty

Ah meaning Anna

Yack for Jack (doll)

Book

Gigi—grandfather

List any other noteworthy accomplishments

Waves bye bye when you put on a coat or say it Tries to put on hat when he sees it Combs hair Blows nose when you ask him to Pulls on toilet strap when he is through

Were there any difficulties connected with teething? Explain *First 4 teeth had hardly any trouble, but with the last 2, he had diarrhea He's getting another tooth and also has diarrhea*

Have there been any special occurrences in the family (moving sickness in

the family, etc.), which have influenced the child or affected his behavior?
Describe *None so far*

IV What habits does your child have of which you do not approve? *None so far*

How have you tried to guide the child's actions? *If he has done something that he isn't supposed to do, I take him away saying 'These are not for you to play with—come, let's play with your things'*

Has discipline or punishment been necessary? Explain *No*

Can the child be left alone in a room to play by himself? *Yes*

For how long? *For a few minutes—then wants company—because of 4 adults in the house There is always someone around so I guess he misses it when no one is in the room*

What are his reactions when he is left alone? *Plays for a few minutes then looks for company*

How does the child react to visitors and strangers? *Shy*

Can the child be left with strangers? *Haven't tried it as yet*

How often is the child left with a sitter? *None so far If you consider family sitters then it's about once a week There are 4 adults in the family, so I guess we don't need outside sitters*

V. What kind of a bed does the baby sleep in? *Regular adjustable child's bed*

Does the child sleep alone in a room? If not with whom? *Sleeps with mother and father*

State hours of sleep *Day 2 to 4 hours Night 9 to 11 hours*

Is there a definite bedtime? *No, when he is ready and sleepy then I put him to bed*

Is there any difficulty at bedtime (e.g. crying resisting prolonging play)?
If I've put him too early then he resists, so I wait until he's ready and gets sleepy

Is the child a sound or restless sleeper? Describe *I would say he's a sound sleeper, but if something bothers him as a stuffy nose or teething then he's restless*

Does the child have any unusual sleeping habits? Describe *Sucks his thumb and must have a wash cloth or piece of towel in his hand*

What kind of covers or restraints are used? *I try to tuck one blanket under the mattress, but he manages to get out anyway*

Have there been periods during the first year of life when the child slept less well than usual? *There was a time when he wanted to get up and play for an hour or two—or as I mentioned, when something was bothering him then he would wake up*

Why do you think this happened? *He was teething or had diarrhea*

When did the child start to sleep through the night? *He still gets up one or two times during the week, and then a few days will sleep right thru*

In what position does the child sleep (back face side etc)? *Back and side*

Has he always slept in this position? *Yes*

What happens when he wakes in the morning? What do you do? What

does he do? *When he wakes in the morning he talks to himself until someone stirs then he stands up and shakes the side of the crib and talks away I get up immediately because I know he is wet up to his ears, and I want to change him*

VI How many stools does the child have each day? *2 3 times*

Describe (hard, soft, other) *Sometimes hard and sometimes soft—it all depends on his diet*

Does the child tend to have bowel movement at the same time every day? *Yes*

Does the child indicate in any way that he is about to have a bowel movement? Describe *He grunts*

Has either constipation or diarrhea been a problem? *I've had it but overcame it quickly*

If the child has been constipated on several occasions has there been any apparent reason for it? *None*

It is normal for children of this age to show interest in and want to play with their bowel movements What have you observed in your child? *He hasn't played with it*

How often and for what reason has it been necessary to use

| | |
|----------------|------------------------------|
| Suppositories? | } <i>Haven't used as yet</i> |
| Laxatives? | |
| Enemas? | |

If there has been diarrhea on several occasions has there been any apparent reason for it? *Teething*

What have you done about it? *Given more liquids and not too coarse and starchy foods*

VII What playthings does the child like? *Blocks, books, balls*

What playthings does he have that he does not like? *He seems to like them all*

What would the child rather do than anything else? (Not answered)

What does he like to play with that is not allowed him? *A drawer of silver In the toilet—he swishes his hands in the water Pull towels out of drawer*

Where does the child usually play? *Kitchen and living room and bedroom*

When was the play pen begun and given up? *Began in the 3rd month—7th month*

Does the child enjoy his bath? If he does not is there any apparent reason for this? *He enjoys it very much*

It is normal for a child to be interested in his or her genitalia Has your child ever played with himself or shown such interest in his bath or at any other time? *He played with his genitals as soon as he was bare and in his bath*

What sort of games does he like to play (including peek a boo patty-cake bye bye)? *Peek a boo—patty cake—bye bye Building blocks Running all over the bed so I won't catch him*

In what does he imitate you? *Chewing gum—he moves his mouth up and down when I make a clucking noise—he tries it, too Combing hair*

- In what does he imitate others? *Singing—dances—many other little things*
- VIII On the average, how often a day does the child cry? *Once or twice*
 When and why does the child cry? *When he gets up and I haven't heard him When he has nightmares*
 What do you do about it? *I pick him up and hold him until he quiets down*
 Do you think the child cries easily? *No*
 Have there been periods during the first year of life when the child has cried more than usual? *Why do you think this was?*
1) Yes—when he had cramps—it was in the 2nd or 3rd month
2) When he has fallen out of the carriage, bed, etc
- IX Has the child ever displayed any jealousy? *No*
 What are the things or situations that seem to frighten the child? *Loud noises Mixmaster Vacuum cleaner*
 Are there any particular things or situations that seem to anger the child?
When you try to stop him from getting things or keep him out of a room that he wants to get into When he drops a toy and you don't pick it up
 In what way does the child show affection? *Crying when people (family) leave to go out Smiling and crawling to you when you come into the house Wanting to be held in your arms*
- X What do you think of the ad lib (self-demand) way of bringing up babies?
I think it's the best and only way to bring up a baby I don't believe in forcing the baby to do things that he isn't ready to do and especially eating
 Do you think this has made a difference in your baby? *Yes, I think it has—he is a very happy and contented baby*
 To what extent has the ad lib schedule
 (a) fitted in with or modified your household activities? *The baby's ad-lib schedule sets the pattern for the day's activity—each day is different I never know what to expect*
 (b) fitted in with or modified you and your husband's going out together? *His work is so that he is busy nights we seldom go out together but when we do, we make sure the baby is asleep*
- Has the presence of the baby fitted in with or modified your activities in the way you expected? *I believe it has modified it some I'm always in I seldom get to go out at night—not that I regret it—I believe I have something much more valuable to show for it*
- XI Questions to be filled in by the mother
 One of our interests in this questionnaire is to find out how your health has been since the birth of the child
 a) Would you please describe briefly how you have been feeling *I was in bed for about 3 or 4 weeks after birth and when I get tired or do too much bending my back bothers me*
 b) For how long a period after the birth of the baby did you feel unusually tired? *It seemed months before I was able to feel up to par—I try to do too much*

How much time are you able to give in "just playing" with the baby? *Not very much because of the housework. Four adults and a baby in the house, so I'm always kept busy. When I feed him we play with his blocks and I have to keep picking up his toys.*

It has now been a year since you were in Rooming-In. How do you feel about it now? *It's the best thing that could have happened. I wouldn't want it any other way.*

Would you want it again? *Yes.*

Do you think the Rooming-In experience has made any difference in your baby? *Yes—he got into a schedule of his own and I think he felt that he could be taken care of as soon as he cried.*

Describe in your own words the kind of person you think your child is: *I believe he is independent—he likes to be left alone at certain times and do things his own way. He is happy and content. He is always busy trying new things and doing new things.*

XII. Questions to be filled in by the father.

How much time are you able to give in "just playing" with the baby? *A few hours in the morning and in the evening.*

How much time are you able to give in caring (bathing, feeding, putting to sleep, etc.) for the baby? *Very little.*

Describe the kind of person you think your child is: *A very pleasant child, at ease with most people—eager to learn things.*

Do you have any additional comments beside those already given about Rooming-In and ad-lib? *No.*

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COVER MEMORIES IN FORMATION

By HANNA ENGL KENNEDY (London)

In the following pages I would like to discuss some early childhood memories as they were told to me by a child at the beginning of the latency period. The opportunity for this study was rather unique as Bridget was under my care from the age of nine months when she was admitted to the Hampstead Nurseries. She returned home shortly before her fifth birthday. I was thus responsible for most of her early upbringing could make first hand observations on her development and as her substitute family mother was an important early love object.

The development of this child is interesting for various reasons but in this paper I want to concern myself chiefly with her present memories of her experiences at the nursery as they seem to me of interest for the study of the formation of cover memories.

EARLY DEVELOPMENT

Bridget is an attractive vivacious dark haired girl of mixed parentage an Indian father and an Irish mother. She was born in July 1940 and is the second youngest of five children of whom two boys and two girls are living at home now. She came from and returned to an extremely good and harmonious working class home which had to be broken up during the War because of bombing and the parents' War work. There is no financial stress or material need in the family but living conditions are cramped. Her mother especially is an emotionally warm woman demonstrative and outspoken in her affection for the family. Most of this affection was concentrated on Bridget during the early months of the War as the only child living at home at that time. She is said to have been a happy contented and very good baby normal if not advanced in her physical development. She was never breast fed always a good eater eager for her food and at three months she took to a mixed diet without difficulty. It appears that her first object relationship was an excellent one and satisfactory for both mother and child. Sudden separation from her mother at the age of nine months was followed three months later by the birth of a baby boy. This made visiting during the first period at the nursery almost impossible for the mother and undoubtedly increased the traumatic effect of the separation.

She was unhappy and could not settle down for several weeks and soon afterwards began to show many problems concerning her daily handling and

upbringing, which manifested themselves in various forms in the different phases of development, but persisted throughout her stay with us. These difficulties showed themselves first in the feeding situation where her intense greed and inability to stand even a minimum of waiting periods, often made eating impossible. Temper tantrums became a usual occurrence at mealtimes, and her complete refusal to be comforted in the real despair that followed, was typical. Her greed greatly exceeded her appetite and our gradual, persistent attempts at helping her to gain control were doomed to failure until she was nearly three. She then became rather faddy with her food and concentrated her greed on puddings, sweets and chocolates.

Parallel to this craving for food was her direct craving for love and affection. With the exception of the first few months Bridget's parents visited regularly once a week. Later when she was older and the air raids less frequent, she occasionally spent a day, a weekend or even a few days' holidays at home. She had a good relationship throughout to both parents, showing preference for her mother at first, and for her father during the oedipal phase. She showed no sign of attachment to any member of the staff until eighteen months old, and disliked the handling involved in the routine physical care. Later she formed a strong relationship to me, which for various reasons proved exceptionally difficult to use for her character development, and instinct modification. In all respects Bridget was exceedingly passionate and demanding, and determined to gain satisfaction for her insatiable craving for love. She continually wanted to be fondled and reassured, and took every attempt at restriction as an indication of complete loss of love. She was very possessive and unable to separate from her love objects, especially jealous of all rivals (brothers and sisters as well as other nursery children), and quite unable to get any satisfaction and contentment from these relationships. She was clinging and exaggeratedly friendly to visitors and new workers, always wanted their exclusive attention. From about three years onwards she showed particular interest in male visitors, but nursery life provided little opportunity to show clear signs of oedipal wishes. It is evident that Bridget suffered greatly from her inability to get satisfaction through her inability to bear frustration.

Perhaps the most serious difficulties in her upbringing were encountered in her training for cleanliness. Lenient training was started at home with occasional successes, and continued in the nursery on much the same lines until she was fourteen months old. The following four or five months she refused the pot completely, and every attempt caused a temper tantrum. After a few weeks interruption, training was started anew, and she would then remain on the pot for a few minutes if sufficiently entertained, only to get up just in time to wet the floor or her knickers. She gained bowel control at two and a half years, but took considerably longer to achieve control of the bladder. In fact, her habit training was an almost classical example of our theoretical knowledge concerning the various stages of superego formation which are necessary before success is permanent. Some of these examples have been published elsewhere.(1) Bridget

reacted to every slight emotional upset with incontinence, and was not reliably dry during the daytime before the age of four and a half. She suffered from nocturnal enuresis until several months after her return home.

There were similar though not such severe problems regarding her aggression. Between thirteen and eighteen months she had several temper tantrums daily, and for several years occasionally reverted to such outbursts. At about the same time she became very aggressive toward other children, which of course is normal at that age, but again she was quite unable to check her impulses. She used biting as her main form of aggression. At times she was stubborn and very easily offended.

Bridget's exhibitionism was as pronounced as all her other manifestations of instinctive urges. She proudly showed off her body when undressed and wanted to be admired both by the staff and the other children, especially the boys. She was easily excitable at such times and used to invite other children to sexual games. She was very particular about her clothes, always wanted new and clean things, and usually found fault with the garments she was expected to wear. Occasionally she tried to draw attention to herself by good behavior or some achievement, but more frequently chose to show off with provocative and disruptive attitudes in the group.

She went through a very marked and prolonged phase of openly showing her penis envy. First she denied being a girl, then pretended ignorance in regard to sex differences and referred to all boys as 'she'. Next followed a period where she imitated boys, e.g., by urinating in a standing position, by trying to join their games or herself initiating boyish activities. At about the same time she developed acute fear of dogs which, for a short time, disturbed her sleep. For many months she complained of pains or hurts which were either purely imaginary or exaggerations of minor ailments.

It was most interesting to observe the fate of her strong exhibitionistic tendencies when they clashed with the manifestations of her penis envy. She ceased to exhibit her body, often did not want to undress, or only do so in seclusion, and was tearful and unhappy in every situation that aroused in her a feeling of inferiority. She also became unable to perform tasks which required physical strength or skill, the very same activities that she formerly used for showing off. Her exhibitionism thus was not modified but temporarily overshadowed by instinctive urges in the service of her penis envy.

It is noteworthy that there was neither noticeable thumbsucking nor masturbation. This is probably due to the fact that she had established a very early and intense object relationship to her mother, and therefore before entering the nursery had reached a stage of development where gratification is expected from the love object and can no longer be attained by autoerotic activities. We can assume that the mother's loud and demonstrative affection had enabled her to reach this phase earlier than we commonly find in children, and that part of her great unhappiness and lack of satisfaction at the nursery was due to her inability to gain pleasure autoerotically.

LATER DEVELOPMENT

I was able to follow up Bridget's development during the last two and a half years since she returned home. She has developed into a very normal, well adjusted child in the latency period. She appears secure and satisfied and evidently has been able to deal with her instinctive urges effectively. Her relationships to the family are excellent, she has strongly identified with her mother and elder sister and takes delight in typically feminine activities. She is protective and tolerant towards her younger brother, but chooses the company of girls in preference to boys who, she thinks are too rough. Her social contacts with children and adults are very good, she is popular and not at all shy, yet does not cling to strangers as she did formerly. She still enjoys loud, frank signs of affection, cuddling, kissing and fondling, and is herself demonstrative in her love but her mother seems to satisfy her completely in this respect. She is no longer demanding receives presents with pleasure but is very ready to share, and her former possessiveness has been successfully turned into generosity. There is evidence of other reaction formations and she shows definite signs of pity and shame. She is a good eater, neither faddy nor greedy about her food. She takes keen interest in school and is said to be a good scholar. Her enuresis has cleared up, she has no special fears and creates no difficulties in management.

MEMORIES

Since her return home in June 1945, I have visited the family on many occasions, the first time after one year and subsequently at two or three monthly intervals. It was possible to arrange to see Bridget, both in her own home with the family, and alone on various outings and walks. It is from these visits that the following material has been collected.

To begin with there was an almost complete amnesia for all that happened before her return home. When asked about her memories she would recite one or the other incident she had been told by her mother, or else make vague statements like "we had lots of toys there" etc. From the beginning, however, she felt some kind of familiarity with the names and occurrences I discussed, an undistinct form of recollection without being able to recall. This perhaps was brought out clearest in her first reactions to me, when we met after one year's separation. She had been looking forward with considerable excitement and expectancy to my announced visit, and then received me with a completely estranged stare and the words "You have changed—your face has changed." Later on a walk, she held my hand most of the time, gazed at me intently, and gradually brought a few memories chiefly regarding my clothes. She made correct statements about articles of clothing which she had seen before and those that were "different."

On this first visit when she was still unable to verbalize her memories, she acted them out. On our walk in the neighborhood of her home she had a continual urge to urinate. At this time, bladder control was no longer a problem to her, and there has never been a recurrence of a similar situation since. It is likely that some children might never go beyond this stage of acting out their early childhood memories in this manner, at this age.

Bridget, I think, found links to her early experiences again through her relationship to me. These memories are preconscious and come up by very definite associations—many interestingly enough through familiarity of locality.

Looking at the material as a whole, it is easy to distinguish between incidents she only knows from reports but does not actually remember herself, a few isolated facts (for instance a swing in the garden) and such memories which appear clear and vivid at the time of remembering and which have undergone some definite distortion. The first group are hearsay memories which are common in both children and adults, the second group may or may not contain important early material. For instance the memory of the swing may represent the pleasure she experienced in this activity, but we have no possibility of further investigation. It is the last mentioned group which most specifically deserves the name of potential cover memories.

These memories have a few common characteristics. They strike one as insignificant, isolated pieces, outstandingly clear and colorful in intensity. Bridget is invariably the central figure in them and I am almost always the object. They are distorted in different ways and varying degrees: most of them make use of the specific mechanism of condensation (e.g. frequently repeated everyday occurrences are remembered as single incidents). They have thus most of the special characteristics of screen memories that Freud described in his early paper on Screen Memories (2). In this paper he also first suggested a grouping of screen memories based on the temporal relation between the screen memory and the memory it screens. He found that there were three possibilities: 1) Retroactive or regressive (*rucklauffige*) cover memories where the content of the screen memory belonged to the first years of childhood, while the thoughts represented by it belonged to a later period in life, 2) Encroaching or interposing (*vorgreifende*) cover memories, where the content of the screened memory lies chronologically beyond the screen memory, and 3) Contemporaneous or contiguous (*gleichzeitige*) cover memories, where the connection of the screened and the screen memory is not only through content but also through contiguity of time.

While it is possible to group all adult cover memories in this man-

ner it will be self-evident by the nature of the material that this cannot be done in our investigation.

We can assume that the formation of regressive cover memories belongs to a later period in life, and that probably most of our material will belong in the third group, the contemporaneous or contiguous. In order to prove this, however, we would have to obtain the associations necessary to analyze each memory fully. We know that this cannot be done, but, I think, the detailed knowledge of the early development that I have tried to outline briefly above, should enable us to understand much of the now unconscious content of the memories. They are, as yet, much nearer the surface and distortions much less elaborate and complicated than in the case of an adult. We also no longer need proof of accepted psychoanalytic findings, and our interest therefore will be directed more to the mechanisms used in the formation of cover memories than their actual content.

On closer examination it became clear that Bridget's memories can be grouped into three categories according to the modification they have undergone.

1. MEMORIES WITH MINOR CHANGES IN CONTENT AND REVERSAL IN AFFECT DUE TO HALLUCINATORY WISH FULFILLMENT

Example 1: On a walk in the neighborhood of the nursery, at the other end of London from her home, she suddenly remembered that she had been here before and remarked, "A lady once talked to us here and gave us sweets." Our children had won the heart of a few elderly people who used to meet them frequently on their walks and sometimes gave them sweets.

Example 2: On another walk she recognized a baker's shop and remembered, "Once you brought me here on a walk and bought me a bun." Many different members of the staff had taken the bigger children to this and other shops and had bought them buns on their walk.

Example 3: On one of my recent visits she practically greeted me with the announcement: "I told my big brother yesterday that in the nursery you always used to have tea in the kitchen, and that you sometimes took me along and gave me a cup of tea and cake." This again was a frequent occurrence but not invariably connected with me. Usually this privilege for Bridget ended up in a scene because she could not have all the available food for herself.

Example 4: The first memory that Bridget ever told me was given as proof that she recognized me, and was, "Once you took me to a restaurant and bought me ice cream and lots of cakes." On a few special occasions during her stay at the nursery, I had taken her out for tea. This particular memory, however, was so clear and vivid that I am almost certain it referred to the farewell outing, the day before she returned home.

I have tried to emphasize in my description of Bridget's early develop-

ment that this child has had an unusually unhappy and frustrating early childhood, that her craving for love and open affection could not be satisfied by any other person than her mother from whom she was separated at a time when the need for her was greatest. I have also tried to describe all the manifestations of this intense need for love, her demands for special and preferential treatment and material tokens, especially food. All these memories point to original experiences where she should have gained satisfaction, but where the intensity of her greed made this impossible. It now appears as a pleasant memory and entails a strong element of personal gratitude to me, which becomes even more apparent in the tone of voice and manner of talking than the actual memory.

The manifest content of the memory thus has certain characteristics in common with fantasies and dreams, an element of hallucinatory wish fulfillment. This mechanism might readily serve as an explanation for the myth of happy childhood.

The first example given above is perhaps most clearly a potential screen memory, the incident is insignificant and isolated from any emotionally charged content, and the object removed from the original love object (i.e., a strange lady). Yet it is essentially similar in content to the second memory described, which is already nearer to the true material contained. *The manifest content in all the memories in this group is centered around being given food, and thus clearly represents her oral greed which I have discussed before.* We know that underneath this craving for food was her craving for love which was so very pronounced in Bridget. The first two memories date back to a time of her later childhood when she had already joined the nursery school group, which we must recognize as a pointer. They also clearly contain a strong desire or wish which she had wanted me to satisfy, and we may assume, on the basis of our theoretical knowledge and our specific observations on this child, that these memories represent her former strong penis envy. The third and fourth example quoted point really in the same direction but are more ambiguous. Being allowed to have tea with the staff was a special privilege which was a sign of being loved, for Bridget. It invariably aroused a conflict in her because she expected her love object to gratify her instinctive desires. These of course were manifold and differed in accordance with the relevant phases of development. Thus it may represent on one level the frustrating experiences in general which she encountered with all her instinctive urges, or it may represent the more specific frustration she met with regard to her wish to be a boy. Similarly, I think, that the memory of her last outing with me, before her return home, might easily contain the whole of her early relationship to me, in a nutshell as it were, and distorted as "in

all these years you gave me all I wanted, and lots of it' (i.e., lots of cake). It is obvious that on a deeper layer it may again represent her penis envy.

2. MEMORIES WITH MINOR CHANGES IN CONTENT AND REVERSAL IN AFFECT DUE TO EGO DEVELOPMENT

I have tried to point out that the process of socialization was particularly slow in Bridget. Her instinctive urges evidently could not be controlled by the ego, and the first signs of instinct modification were interrupted by long phases where the instinct broke through in its original form. I have described that since her return home, which roughly coincided with the beginning of the latency period, she shows satisfactory reaction formations and sublimations. Her former greed, possessiveness, jealousy and envy have now become enjoyment in sharing and giving away her belongings.

The memories that I propose to put in this group show very definitely a distortion of the original affect in the light of her newly acquired modification of instinct. It is, I think, the most common mechanism of distortion that we will find in latency period children.

Example 5 Bridget's mother arranged a birthday party for her seventh birthday. She was particularly happy on this day and a perfect hostess to her guests. She urged them to eat, allowed them to play with her new presents. In short she saw to it that everyone should have a good time. On that day she told me the following memory: 'Once I had a birthday in Netherhall and my mummy came with a big cake and gave a slice to every child.' She indicated that she had greatly enjoyed sharing her cake at that time and that it had been a very pleasurable experience. Again the facts are correct: every year on her birthday her mother brought a cake to share out amongst children and staff. Bridget never verbalized a complaint but her resentment for not being given the whole cake for herself was always very open in her behavior and repeated itself every year.

Example 6 Another time when I gave her some sweets she suddenly remembered. Once my mummy came and brought me sweets and gave one sweet to a little girl who was crying. Bridget's mother always was very sympathetic with children who had no Sunday visitors and often gave them sweets. As a young toddler an incident like this caused an outburst of anger against the mother. Later there were instances where she first refused to share her sweets but the pressure of mother's demand made her give in unwillingly in the end. She of course often consented to share in her mother's presence but then made return claims on the children at a later time.

In both these examples the present affect in situations of this kind has been imposed on experiences of the past. This is not a general mechanism for all her early experiences.

3. MEMORIES WITH DISPLACEMENT OF AFFECT TO A DIFFERENT CONTENT

Example 7 On one of our walks again in the neighborhood of the former nursery, we came to a footpath which has railings in the middle. Bridget remembered that on top of the hill was the school that a few of our children had attended, and then told the following story: "You took me here sometimes to fetch the school children home. Once we chased each other under the railings, you told me to stop but I went on and on, and you got angry. Our nursery children knew that the school teacher used to punish her pupils for climbing these railings but our staff did not object strongly to such harmless pleasures as chasing around the railings."

Example 8 Soon after, she remarked that she was too small then to go to school but as far as she remembered they went to a kind of school (nursery school) and there was a piano: "Once I kept on playing the piano and you told me to stop, but I continued and you got very angry with me." There really was a piano in our nursery school and the children were not supposed to play it. The rule however was never rigidly enforced.

It will hardly be necessary to expand here on the methods in upbringing used in the Hampstead Nurseries. We did not believe in giving the child "complete freedom" in the sense of "modern" education. There were rules and regulations intended to maintain the order and routine so necessary for the children's welfare, and such restrictions as would help them to strengthen their ego and build up their personality. We did not enforce these rules but made gradual persistent demands, and expected a slow progress rather than complete obedience.

This, I think, we must bear in mind when investigating the last mentioned memories. The two incidents would not have roused real anger in any member of the staff, and we can immediately recognize the displacement. The type of behavior it describes was not unusual for Bridget, it was one of her ways of showing off and getting attention, and has thus remained undistorted. In my account of Bridget's early development I have stressed the difficulties we encountered with her instinct modification. There was an all out battle with every single instinctive urge, and a particularly strong and prolonged one over her training in cleanliness. It is this that I believe to be the screened memory. We do not know of any masturbation conflict in this child, but otherwise would probably assume that such a conflict is contained in these memories. They do represent the original objects with their correctly attributed affects, the frustrating adult, and the child who experiences pleasure as well as guilt feelings, for not conforming to the demands.

CONCLUSIONS

We will be in agreement that these memories are not formed cover memories but cover memories in formation. We have found that, although they have certain characteristics in common with the screen memories of adults, they cannot be grouped in the same manner. The material presented in this paper was divided into three categories according to the chief mechanism of distortion. We cannot conclude that these are the only or the most common mechanisms used in the formation of cover memories, nor can we say with certainty that they are specific for this individual child or her early experiences. We will expect further distortion and modification in the manifest content, but we cannot predict any particular development. We do not know if the three mechanisms are different stages in the same process of distortion or if certain early experiences show definite tendencies to be distorted more readily by means of any one of the mechanisms described. It is more likely, however, that the mechanisms used in the formation of cover memories depend on the personality of the individual. We generally expect to find definite defense mechanisms suitable to certain types of personalities in accordance with their constitutional make up and their acquired character.

We know that childhood memories do not give a true picture of early experiences as they have actually occurred. They are built up at a later time when for one reason or another, an early experience is reactivated. It is likely that the renewed contact with me revived these memories in Bridget and it is probable that they were built up partly on the occasion of the visit and partly in the interval between visits.

The particular situation in which this material was collected seems very favorable, her emotions now are far removed from me, and I represent for her a part of the past with which I bring her in contact on every visit. In cases where the relationship to the mother has been continuous and uninterrupted it will be more difficult to get this type of memory verbalized.

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ON THE SLEEP DISTURBANCES OF EARLY CHILDHOOD

By SELMA FRAIBERG (Detroit)

Children in their second year often show a variety of sleep disturbances which range in intensity from a brief waking at night to profound disturbances in certain cases, with wakefulness which may persist for hours or for the entire night. Because night waking occurs so frequently at this age, pediatricians and those who do research in child development have come to regard this problem as typical for the developmental stage. Thus Gesell(4) in his *behavior profiles based on large scale studies of infants and small children at the Yale Clinic*, includes night waking and the reluctance to go to sleep as one of the developmental features of the period from fifteen to thirty months.

In clinical practice we have occasion to study children of this age who suffer severe and exaggerated forms of night waking which almost totally affect the capacity for sleep. Typically the child wakes screaming after a brief sleep interval *requires long periods of holding and may return to sleep only after hours of tense wakefulness*. Many of these disturbances are progressive and within a few months achieve the proportions of a major illness which dominates the young child's entire mental life. The anxiety spreads to embrace other functions of the developing organism. In the daytime behavior we may observe distortions and transformations of affect. In addition there is usually an arrested developmental picture with failure to acquire new vocabulary or motor skills for the period of the acute phase of the illness.

To the psychologically trained observer night waking in either its moderate or severe forms would be regarded as a symptom. The fact that a particular symptom should be *considered typical for an age is of special interest to us* since we would then expect that its relationship to developmental problems of that period could be investigated and secure for us some additional knowledge of the early mental processes.

In the study that follows I have brought together material from the observation and treatment of a group of small children under two years of age who suffered sleep disturbances of several types and in varying degrees of involvement. In the cases brought for treatment the sleep disturbance usually had persisted for a long enough time to cause serious

concern to the parents. In all these cases night waking had become an established pattern, beginning with the typical anxiety cry and requiring long periods of holding and comforting by the mother.

For purposes of this discussion it seems desirable to treat separately two conditions which we find to have an important bearing upon the onset of this symptom; i.e., the factor of trauma and the anal conflicts of this age. Illustrative case material will be utilized in both sections. A more detailed case presentation will be made in the third section to illustrate the progression of a sleep disturbance from the level of an early anxiety state to a neurosis.

THE ONSET OF SLEEP DISTURBANCE AND THE TRAUMATIC SITUATION

Among the children studied the circumstances of the onset of the sleep disturbance showed a striking feature in each case. To cite a few examples: At twelve months Jimmy began to waken several times a night with terrifying screams. He clings to his mother as if he cannot bear to let her go. For hours he lies in her arms, tense and fearful. The beginning of his night waking coincides with the period in which his older sister begins vicious and savage attacks upon him. In two other cases, separation from the mother is the exciting cause of the sleep disturbance. At thirteen months, Ellen develops a serious type of night waking during the absence of her mother for a three day period. Following the mother's return the sleep disturbance continues in spite of the reassuring presence of her mother. Peter, at sixteen months, wakes several times a night with cries of terror. He is often sleepless for hours. The night waking came on soon after the mother returned from the hospital with a new baby.

We learn of sleep disturbances which follow a tonsillectomy or an injection. And in the case of fifteen-month-old Danny, the night waking followed an ordinary visit to the doctor's office where he had protested violently against a throat examination and was restrained. He screams in his sleep before waking, "Let me down! Let me down!" as he had cried out on the examining table.

At twenty-four months, Sally awakens with terrible cries. She clings to her mother and refuses to go back to sleep, "cause then I hear the noises!" The sleep disturbance came on soon after she returned from a two-weeks visit to her grandparents. Certain observations of the child caused the therapist to suspect that she had observed a sexual act. Through tactful questioning, it is learned that the child slept in the bedroom of her grandparents during her visit. Subsequently the child's observations are brought out in treatment.

These brief examples exclude specific findings in each of these cases. Our only purpose in taking such liberties with our data is that of establishing the primary relationship of the sleep disturbance and a traumatic situation. Yet, as we review the exciting causes of these sleep disturbances we are struck by the fact that for the most part these situations are not

exceptional in the life of the child's second year. Attack by a sibling, separation from the mother, a visit to the doctor's office, are not unusual events. These same situations may produce anxiety in any child but not every child develops a sleep disturbance.

It seems necessary then, to explore this problem from two points of view, first, what factors operate to give such events a traumatic character and second in what way does anxiety succeed in breaking through the protective barriers of sleep at this early age.

For our purpose it is necessary to follow the example of Freud and differentiate two types of situations which bring about anxiety. Freud distinguishes a *traumatic situation* and a *danger situation*(2). The traumatic situation is that of helplessness, the experience of being overwhelmed and indefensible. All anxiety is reducible finally to the original situation of helplessness. Through the memory and recognition of the traumatic situation the ego may anticipate this situation of helplessness whenever the occasion arises which reproduces the original or prototype of the experience. The second type which Freud describes as the danger situation is distinguished by the ego's faculty of anticipation. Its capacity of anticipating danger gives it the advantage of utilizing those methods which it has available for preparation and defense against anxiety.

Normally the second year child has already made some progress from the situation of trauma and helplessness to that of anticipation of danger. Where pain is the inevitable result of certain acts he learns to anticipate the consequences and will either avoid the painful situation or gain control of it through the means available to him. But the child of this age is confronted with a vast array of overwhelming forces. Many of these are unpredictable and beyond his comprehension. He stands up and a nameless force throws him down. He climbs on the chair and the temperamental piece of furniture spills him to the floor. He wants the lamp and the lamp wrestles with him only to send him crashing to the floor a moment later. His brother kisses him tenderly, his brother delivers a healthy blow to the side of his head. Mama is pleased when he eats his carrots and displeased when he eats the contents of his potty. Some of these factors while retaining their unpredictability will yield to scientific investigation. The second year child begins to learn, for example, that departure is usually followed by return. Others have no rationale and remain for him perversities beyond his comprehension. For these reasons no child, no matter how tenderly cared for, can escape anxieties. Danger is omnipresent. Animate and inanimate are not differentiated. The furniture is perceived as hostile if it overturns him.

At this age all danger is perceived as an objective threat. But we must now add a subjective factor. Impulses from within the self may bring

about an objectively dangerous situation. Certain acts, the child discovers, will bring about his mother's displeasure, and he now fears disapproval in the same way that he fears loss of the mother. Now, or earlier, he has submitted to toilet training for no better reason than it pleases the mother. He willingly becomes partner to a fraud in which mother exclaims over each stool, growing ecstatic as mothers will, only to see this gift of love flushed indifferently down the toilet. To fear of loss of feces is added the danger that through soiling through refusal to defecate in the pot, he will lose his mother's love. We observe that even in those cases where toilet training has proceeded without threats or coercion the child may still perceive a threat through his observation of the fate of his own feces.

At this age, then, the child fears loss of the mother and the mother's love and he fears injury to himself. Yet, if he is reduced to helplessness whenever he loses sight of his mother's face, or if he avoids all motor activities or situations in which he risks injury to himself, we should certainly conclude that we had an abnormal child. That this actually happens in certain cases of very young children is known to us. But what of the normal child? How does he master these traumata and bring them under control?

We are interested then in the means by which the second year child commonly defends himself against anxiety. His mother must certainly rank first as guardian of his psychic equilibrium but now with his developing independence, his locomotion and new motor skills, he finds himself more and more in predicaments where his mother can only come to his aid after a minor disaster. He has learned further that certain acts will bring forth the pain of his mother's disapproval and discovers that love and gratification will not always be forthcoming from this very important person. All in all this developing ego finds the necessity of dealing with certain quantities of anxiety without the aid of his mother, or with minimal support from her.

Freud tells us that the ego gains mastery of the traumatic situation through turning the passive situation of being overwhelmed into the active one of anticipation and preparedness. He has stressed the importance of this binding process in the child's early development. In a memorable example, Freud reports his observations of a game played by an eighteen-month-old boy⁽³⁾. The child engaged in tireless repetition of a game in which he caused his toy to disappear, or would fling it away, then would recover it with exclamations of joy and welcome. In this way he dramatized departure and return specifically in relation to his mother and so mastered one of the universal anxieties of early childhood. In another context Freud remarks on the familiar peek-a-boo games which we play with the small child in which through hiding the face and uncovering it we play disappearance and appearance⁽²⁾. The spontaneous games of small children and

the nursery techniques of the sensitive mother all serve this very important function

So it is that we play Ring around the Rosy with the child who is learning to stand up or to walk. In the last line we sing "All fall down!" and the child delightfully collapses on the floor. Through such devices he learns to master his fear of falling. "I am not made to fall. I choose to fall." In the same way the child who is repeatedly attacked by an older sibling may avenge himself on some object which offers no risk of retaliation: a stuffed toy or a piece of furniture. An injury caused by bumping the forehead on a table was always handled expertly by the old-fashioned mother. She would encourage the child to spank the bad table and would kiss the hurt place on the forehead so it will go away. The modern mother will say, "But the table did not want to hurt you, darling!" and the child does not believe her.

We could go on to report the toilet games through which the child investigates the mystery of the disappearance of his stool. The mother of a healthy child may expect to find her own precious belongings lodged in the toilet bowl. At this age too waste baskets, garbage cans, drawers as well as the toilet will further the researches of the child and he behaves comically like the housewife whose careless maid has thrown the silverware out with the garbage. He may retrieve from these excavations some greasy memento which temporarily satisfies him and replaces the original loss. His mother is certain to have difficulty in persuading him to part with it.

In all of these ways then the child achieves control of the stimulus through a repetition of the experience in which the passive situation is turned into an active one: he *does* it where before it was *done to* him. The repetitive activity further serves the very important function of bringing about the necessary conditions of anticipation and preparation in the re-created event so that the strength of the stimulus is reduced as the control is increased.

When we now reconsider the events which brought on the sleep disturbances in the cases mentioned it is apparent that certain of these exceptional situations assumed the character of traumata because of the failure of the ego to meet the event with the necessary physiological and psychic preparations. Further we deduce from the appearance of a symptom that this failure was not made good through the restorative measures of the ego in the subsequent period. This brings us to additional considerations in our investigation of the problem. What factors may operate to fix the trauma and promote its effects for a period beyond the critical event itself?

In the case of fifteen-month-old Danny the sleep disturbance came on following a visit to the doctor's office. He had been restrained on the examining table, his arms and legs held down by the parents because he refused to permit the doctor to examine his throat. He screams in terror: "Let me down! Let me

down! ' This marks the beginning of his night waking. He screams in his sleep, ' Let me down! ' reiterating the terrified cry he used on the examining table. He then awakens and cannot be comforted for hours.

We learn that the reaction of this child to any kind of restraint has always been violent. His developmental history is revealing. He was bottle fed from birth. Solids were introduced at six weeks and he refused them. At three months, when he still refused solids the mother claims that the pediatrician recommended that he be forced to eat. Whether or not such advice was actually given cannot be shown, but between the ages of three and seven months, mother and baby had been fighting a grim battle. The child was forced to eat while his protesting hands were held down. He immediately vomited, of course. Soon he began to refuse even his bottle. The struggle continued for weeks. At one point when the pediatrician allegedly recommended "starving" the child, Danny demonstrated that he could go for days without food. At seven months the mother, in alarm at these developments, returned to bottle feeding exclusively and the child was slowly restored to normal functioning.

Clearly, then, when the physician examined his throat with a tongue depressor at fifteen months, the earlier traumatic situation of forced feeding was revived. The child reacted in identical fashion and was then restrained on the examining table while the examination proceeded. Following this incident the sleep disturbance came on which was to continue for months. Thus it appears that even at this early age, an experience may assume for the individual a traumatic character if it reproduces the effects of an earlier trauma which overwhelmed the ego and left it helpless.

We are further interested in establishing the relationship between the traumatic event and the sleep disturbance itself. We have already seen that, in those cases in which we could obtain some sort of "report" from the small child, the waking followed what was undoubtedly a dream in which the child was taken back to the scene of the trauma. Before waking Danny cries out ' Let me down! ' just as he had during the fateful examination in the doctor's office. In the case of two-year-old Sally we learn that she wakes up because of ' the noises ' . It is established that she had observed coitus between her grandparents during the visit in which she slept in their room. The noises then, are the noises of the grandparents. After waking, she refuses to go back to sleep " ' cause then I hear the noises " .

In other words, the mechanism and the dream form may be said to closely resemble that of the traumatic neuroses. It would be incorrect and far fetched to attempt a closer parallel, or to speak of these early disturbances as traumatic neuroses, but in order to investigate this mechanism we must use our knowledge of the function of the dream in relation to traumatic events. Thus Freud points out that the dreams of the traumatic neuroses do not belong in the category of wish fulfillment but follow

the repetition compulsion. In such dreams in which the patient is brought back to the traumatic situation, the dream work produces a state of apprehension and psychic preparation for the oncoming danger which could not be summoned forth at the time of the critical event. Because these mechanisms failed to prepare the system, the protective barriers collapse under the impact of these excitations, producing a state of helplessness and psychic impotence (3, p. 38).

In studying this mechanism on the level of the small child, it appears that the dream function may serve the same purpose as that of the dreams of the traumatic neurosis. In speaking of the latter Freud says, 'These dreams are attempts at restoring control of the stimuli by developing apprehension, the omission of which caused the traumatic neurosis' (3, p. 37). We have already had occasion to refer to the abreactive devices of this very young child in mastering traumatic situations. We have seen how his play is directed ceaselessly toward repetition of the unpleasurable in order that he may gain control through activity over the situation which earlier had overpowered him. The relationship between this activity to secure mastery through repetition and the dreams of the traumatic neuroses, was established by Freud and provided one basis for his exposition of the theory of repetition compulsion in *Beyond the Pleasure Principle*. Following his discussion of the function of the dream in the traumatic neurosis Freud puts forth the theory, 'Thus the function of the dream, viz. to do away with the motives leading to interruption of sleep by presenting wish fulfillments of the disturbing excitations would not be its original one: the dream could secure control of this function only after the whole psychic life had accepted the domination of the pleasure principle' (3, p. 38). Can we say then that this earlier tendency of the child to effect a binding of excitations independent of the pleasure principle will also appear as a dominant principle in his dream mechanism?

Thus far, then, we have established a relationship between the traumatic event and the sleep disturbance. The mechanism appears to be identical with that of the traumatic neuroses in which the dreamer is brought back to the traumatic event and the dream function is that of bringing about a state of apprehension and preparedness: the psychic requirements for control of the stimulus which could not be produced under the conditions of the original event.

On this level, the sleep disturbance is still represented as an attempt in the dream to establish control of a danger which threatens from without. However, when an instinctual wish has been renounced we have the additional factor that an impulse from within may bring about the objectively dangerous situation. For this reason it is necessary further to investigate the nature of these early sleep disturbances when the factor of toilet training has been introduced into the child's life.

THE CONFLICTS OF THE ANAL PERIOD IN RELATION TO THE SLEEP DISTURBANCE

The conflict between the wish to soil and fear of loss of love appears frequently as the basis of symptom formation in the second year. As a factor in the eating disturbances of early childhood, Editha Sterba has shown how the refusal to eat may be a displacement from the anal sphere, in which the element of refusal is transferred from defecation to eating. (5) As early as the second year we may also observe a reactive alteration of the instinct in which fear and disgust of dirt replaces the original pleasure. Certain common phobias for the most part transitory, will appear at this age in the form of a fear of vacuum cleaners, the drain pipe of the bathtub and other such apparatus, which arouses in the child the fear that he may be swallowed up and caused to disappear like his feces in the toilet.

In the case of a phobia in a two-and-a-half-year-old girl Berta Bornstein describes an illness which resulted from the conflict between pleasure in soiling and fear of loss of love.(1) The case is of special interest in connection with this study because the neurosis took the form of a *refusal* to go to sleep. The child could sleep only with the aid of sedation and then would fall asleep in a sitting posture with clenched fists and a tense facial expression. Analysis revealed that the child avoided lying down because she was afraid that in this position she could not control the impulse to defecate in bed. A traumatic separation from the mother during the period of toilet training at one year gave rise to the fear that she could lose her mother for soiling. In the interval between one year and twenty-seven months there had been no outbreak of symptoms although the child's history during this period showed an exceptional preoccupation with tidiness and disgust in connection with dirt. The neurosis broke out at twenty-seven months when premature sexual excitation brought on an intensification of the soiling conflict. Bornstein brings out similarities between her case and that of Wulff whose report on an illness in an eighteen-month-old child revealed identical factors.

In this respect we find that certain of our cases of night waking can only give further confirmation to the findings of these two authors. However, since our intent in this study is that of exploring the mechanisms which disturb sleep in early childhood and the specific relationship of the early conflicts to night waking we might examine two such cases in which these factors are clearly discernible.

Ellen was thirteen months old when a severe form of night waking came on which resulted in prolonged sleeplessness. Until then the child had had a normal development and had been an unusually cheerful and active infant. She was bottle-fed from birth with some initial difficulties with formula and began her toilet

training at eight months. The mother had early exhibited concern about constipation and frequently employed enemas. This same preoccupation with anal functions resulted in an ambitious toilet training. Although no pressures or punitive devices were utilized, something of the mother's insistence must have been communicated to the child because she early achieved a degree of control unusual for her age.

At thirteen months Ellen's parents took a week-end holiday and left her in the care of her grandparents. During these three nights the child who had never suffered any form of sleep disturbance was wakeful and screaming almost all night long. She called for her mother constantly. Upon the return of the parents and restoration to her own home the child's disturbance continued. She awakened in terror several times a night and begged to be held. The sight of her crib filled her with dread and she wept bitterly at bedtime. After the child was home for a week and the night waking grew worse the mother consulted me.

When I inquired routinely about toilet habits I learned that although Ellen had soiled herself during her stay with her grandparents she had quickly re-established her 'training' when the mother returned and there was 'no difficulty' in that regard. Since I could not visit the child for two days I offered suggestions to the mother pending a visit. I suggested that the mother play 'peek a boo' and 'bye bye' games with Ellen during the day in which mother disappears and comes back very glad to see the baby with a hug and a kiss. It was suggested too that Ellen be encouraged to take her Teddy bear or lamb to bed with her with a comment that the toy would take care of her. Then I broached the subject of toilet training and suggested that this might be an additional tension at a time when the child was extraordinarily anxious and asked if we could temporarily eliminate this training. The mother firmly rejected this last idea but did carry out the other two suggestions with results which were better than they deserved to be.

After the first day in which the mother utilized these devices, Ellen slept through the entire night. She had been delighted with the 'bye bye' games and almost exhausted her mother with her frequent requests to play them again and again. At bedtime she chose her lamb to sleep with her. She cuddled up with the lamb in her arms then just as she was dozing off she sat up, placed the lamb on her pillow then reversed her position in bed by going to sleep with her head at the foot of the bed.

For the next week I received daily reports from the mother. Ellen slept through every night and the mother continued the games and the use of the lamb. Ellen was again cheerful and happy and all went well. Her mother said that she had continued very good so far as toileting was concerned and took this as proof that I must have erred. We were puzzled by this rapid recovery. A month later the mother called to tell me that the sleep disturbance had returned. Ellen was now waking at night in a state of great tension. She would lie rigid in her bed, fists clenched, every muscle taut, whimpering pathetically. She would draw her legs up, squirming and writhing. During the day she had violent outbursts of temper, cried on the slightest provocation and seemed a changed personality. She was physically well, gave no evidence of illness. Once again I inquired about

the toilet training. The mother assured me that that could have nothing to do with it because Ellen had recently begun to have her bowel movements during her afternoon nap! I asked then if the training efforts were continuing, was Ellen being put on the toilet at regular intervals. The mother said that she was continuing this program and that she was certain that the child did not feel any disapproval for her "accidents."

I offered the only advice I could which was to drop all forms of toilet training, even the subtlest encouragement and to reassure the child when she awakened from her nap with soiled diapers. Although dubious, the mother followed through on this advice. Almost immediately the child returned to normal sleeping habits. The daytime temper tantrums diminished accordingly. Now convinced of the meaning of the child's symptoms, the mother made no effort to re-establish toilet habits until a later stage. In a three year interval, the sleep disturbance has not recurred.

We are interested, then, in the origins and progress of this sleep disturbance from the time of a traumatic separation from the mother to its later manifestations. We are struck by two factors in the first sleep disturbance which seem unusual. Although it is understandable that a child should react with such anxiety to separation from the mother, we observe that the sleep disturbance continued after the mother's return and that the toilet habits which had typically broken down during the mother's absence, were immediately re-established. This last factor appears suspicious because it is much more common after such a temporary regression to see mother and child engaged in a tedious retraining process made all the more difficult by the lapse. This child, then, felt it necessary to make an unusual effort to please her mother after her absence. The child commonly experiences the absence of his mother as withdrawal of love. Here the child feels that to maintain the mother's love, to prevent a recurrence of this tragedy, she must keep up her "insurance premiums" and docilely resumes her toilet habits. Also since the soiling and the mother's absence occurred simultaneously, it is quite possible with the infantile theory of causality, that the child interpreted her mother's absence as withdrawal of love for soiling.

The second period of the sleep disturbance provides further clarification. Now the child was having regular bowel movements during her afternoon nap and produced nothing on the toilet. At night we find anxiety waking with the child tensed and rigid as in the attitude of withholding feces. Here, then, the fear of soiling is evident in the night waking. Although she could permit the soiling during the daytime nap, the anxiety broke out at night because, I believe, the loss of the mother, and the fear of losing her were associated with the dark. The waking with the cry of fear, and the child's characteristic posture suggests that she had dreamed that she was about to soil, that she *wished* to soil, but the wish

was not capable of fulfillment because a previous traumatic loss of the mother exerted a powerful restraint at the crucial moment. In this instance we might say that the child who has renounced anal pleasures for fear of loss of the mother's love may experience the return of these wishes in the dream but the dangers which attend the fulfillment of such wishes interrupt the attempts of the dream work and hence interrupt the sleep.

As a further point in our study it is of interest to examine in detail the progression of a single case of sleep disturbance from the level of an anxiety state to a neurosis. In the case which follows the sleep disturbance came on at thirteen months following certain traumatic events and pursued its course on successive levels of libidinal development.

A PROFOUND SLEEP DISTURBANCE IN AN EIGHTEEN MONTH OLD GIRL

When Kathie was thirteen months old a critical sleeping disturbance appeared. She awakened several times a night with an anxiety cry and then for periods ranging from twenty minutes to five or six hours would lie in her mother's arms tense and fearful unable to return to her own bed. Many factors prevented the mother from actively seeking and utilizing help for her daughter at this time. She sought advice from many quarters, tried various unsuccessful methods of handling and only with the onset of an acute phase of the illness was she finally able to follow through on a therapeutic program for the child.

Kathie was eighteen months old at the time her mother consulted me. Five months had elapsed since the onset of the child's illness. The child was now sleepless for the greater part of the night. She was unable to compensate for the loss of sleep through daytime naps so that the physical toll was heavy. At the time I first saw her her appearance was striking. She had a demure little face, round eyes and tight ringlets over her head. She might have been a pretty child but her skin was yellow, the eyes vacant and staring and there was a flabby fatness about her which one would not find in an active child of her age. Her face was completely dull and expressionless. Although she walked capably at this age she showed a passivity and a lethargy even in motor activity. During the early visits to her home she sat in a large armchair while her mother talked with me. She would sit quietly uttering few sounds, completely self-absorbed and listless.

The mother herself was a quiet, restrained young woman with a carefully articulated speech, controlled affect and marked fastidiousness of dress and manner. Her distress over the child was real. She herself was physically exhausted following these five months in which her own sleep had averaged only a few hours a night.

Tracing the history of the illness and the child's developmental history the following factors seemed significant. The nocturnal anxiety attacks began in the thirteenth month, coinciding with the beginning of vicious physical assault

upon the child by a four year-old cousin Joel, who was also a neighbor, was a constant visitor in the house. At this time, the four year-old boy, in the midst of his own oedipal conflicts, initiated severe attacks upon the little girl, striking her, pinching, biting, snatching things from her, and teasing her to the point of hysteria. The relationship between the two children had always been close. There was much confusion in handling these episodes. Kathie's own terror and the beginning of the night waking warned the mother that firm measures must be taken to avoid these attacks, but her own relationship to her sister was such that she could not afford to be insistent on methods of handling. Within a month the situation became extremely serious. The attacks grew worse and the night waking more frequent. Now, on the advice of a consultant, the mother restrained Joel and firmly prohibited the attacks. Kathie was given increased mothering and soothing. With these measures Joel relinquished his hostile assaults. But Kathie's sleep disturbance continued to grow worse and no amount of comforting from the mother lessened her anxiety. She asked repeatedly to be held by her mother during the day. She showed no interest in toys or games. Her attachment to Joel continued, however, and while he was at school, she would ask for him constantly. When he came to visit, as he did each day, she would greet him with delight.

A further examination of the developmental history revealed the following facts. Kathie had been breast fed for nine months. There were no feeding problems. During the first five months she was more wakeful than most infants and required less napping, but the pediatrician felt he could not regard this as unusual. After the fifth month her sleep requirements were normal. At thirteen months the night waking began. At fourteen months toilet training was slowly introduced. The mother felt no discernible resistances and the training was easy. Kathie began to take steps at thirteen months. At eighteen months her speech and articulation were within the normal range of about a dozen words. Kathie had never been separated from her mother for more than an hour or two.

In the first visit to the child's home I carefully reviewed all these factors with the mother with no new results. Kathie sat in a big armchair sucking her thumb and staring blankly ahead. At the close of this nonproductive interview, I was preparing to leave when the front door flew open and a four year-old boy burst into the room. At once the lethargic little girl came to life. 'DoDo!' she screamed and waved her arms. Joel swooped down upon her. He rubbed his face against her little belly. She giggled. He kissed her neck. She squealed ecstatically. He tickled her and squeezed her. Kathie's laughter became more and more hysterical. Then he started on her arm. He mouthed her arm from wrist to neck. With each gesture she giggled expectantly. Then he began to take little nips at her arm. More giggles now a little uncertain. Then he began to bite hard. Suddenly there was a loud outcry from Kathie. He persisted trying to reassure her. Kathie continued to scream. At this point the mother asked Joel to leave Kathie alone. There was no alarm in her voice and I gathered that this was a common occurrence. The mother made no move to interfere although she continued to call to Joel. The noise of Kathie's screaming, Joel's protests and the

mother's calls filled the house. Thinking that for some reason the mother felt she should not act because of my presence I myself interfered at this point. I was standing near the two children so I reached over and drew Joel to my side. With this both children *stopped momentarily and then to my astonishment* Kathie fixed me with an accusing eye and burst into tears again now calling for DoDo to come back to her. DoDo screamed his wrath at me while Kathie's mother picked her up to comfort her. It was plain that no one had welcomed this chivalrous intrusion.

Later in discussing this incident with the mother I learned that not only were these incidents common but the mother had not regarded them as harmful. She usually did interfere when Kathie screamed but she never had been concerned about the erotic foreplay that preceded the playful biting because Joel did this out of love for Kathie and Kathie herself loved it so. Also the mother explained such tickling and nuzzling and biting as I had observed was the sort of play Joel himself was accustomed to with his parents.

Our first task then was to help the mother understand why such stimulation is harmful to a child. With interpretation to the mother we worked out a plan in which all such forms of erotic play were to be prohibited by the mother and further in which play between the two children would be limited to short periods during the day. A few other suggestions were made to the mother pending my return from a brief vacation. I encouraged the mother to help Kathie engage in banging games with pots and pans. Also in preparation for further work with Kathie it was suggested that Kathie be allowed to choose a doll or Teddy bear to take to bed with her with the hope of bringing about an identification with a toy which I could use in play.

When I returned two weeks later there were several new developments. The sleep disturbance had in no way diminished but Kathie had developed a new assertiveness. She had responded to the banging games with relish. Two dolls now began to play an important role in her play. She had chosen the Teddy bear to sleep with her and had developed a strong attachment for Bee (bear) on the basis of their new intimacy. She cuddled him and uttered endearments. On the other hand an abandoned doll was recovered by Kathie and the doll was battered unmercifully flung about and scolded. At the same time our well trained Kathie who had always faithfully asked to go to the toilet began to have several lapses. Her mother handled these casually. Of further interest is the fact that Kathie's table manners suffered a setback. She had begun to throw food and to display outbursts of temper at mealtimes. Yet with all of these breakdowns in training the mother exhibited excellent understanding and confidence. It was at this point that suggestions were made to the mother regarding the toilet. It was agreed that no further efforts would be made to anticipate bowel movements or encourage the use of the toilet. If Kathie should ask to be taken she would comply otherwise training efforts would be abandoned.

During the early visits with Kathie it was possible to engage her in a relationship to me. My social blunder of the first visit created a well founded suspicion of me which took a little time to undo. I brought little surprises for her in

my purse, candies, trinkets, etc. Gradually she began to join me in games of hiding. Then the doll and Teddy bear were brought into these games. Her mother was always present of necessity and took an active part then and later in all such activities. Within about four visits we had progressed to a new game with the doll and Teddy bear. We would put the Teddy bear "to bed" in my coat, tucking him in, saying goodnight and turning off an imaginary light. Then I would make crying noises for the bear whimpering loudly for "Mama." Kathie would then come over to him, pick him up solicitously and hug him. Then she, too, learned to make imitative crying noises and considered this quite a trick.

In the sixth visit, I arrived to find Kathie looking ill and lethargic. Her mother reported a very bad night in which the child had awakened seven or eight times with cries of terror. All morning Kathie had been nursing an injured knee which she received yesterday when she slipped and fell and slightly skinned her knee. Following the slight injury yesterday, she had cried for hours.

We played for awhile with the doll and Teddy bear, putting them to sleep and having each wake up crying. Each time Kathie soothed the crying "Bee" (also stands for "baby"). Then she turned to my purse, emptied its contents on the floor and played with it for awhile. Suddenly in the middle of absorbing play, she burst into a loud wail. Over and over she whimpered "kneel kneel." Yet her cry had a manufactured quality about it. Her mother and I expressed quiet sympathy for the knee but she was not comforted. She cried "Hoe! Hoe!" (hold) to her mother, meaning that she wanted to be picked up. We decided not to pick her up but to offer comfort in words. Kathie howled louder and finally produced a bellow of rage.

At this moment, I picked up the bear and began to sob loudly, much louder than Kathie could. Kathie stopped crying and looked up in surprise. I howled lustily, changing roles momentarily to imitate a worried mother trying to comfort the child. Taking advantage of Kathie's surprised silence, I began to interview the bear. "What's the matter, little bear, what's the matter?" I said over and over. Kathie now moved over to my chair. I repeated "What's the matter, bear?" Kathie spoke up "DoDo?", she said. "What about DoDo?" I said "Eye!" Kathie said enigmatically. Her mother and I looked puzzled. Her mother said that she *has been saying this for days but they don't know whether she means 'eye' or 'I'.* I asked her to show me. "Eye!" Kathie said and covered her eye with her hand. I looked interested. "Head," she continued, and put her hand up instinctively as one does after a blow. Then she lapsed into silence and her hand moved to the genital area where she rubbed herself for a moment. I wasn't sure of what I had seen so I asked her to repeat it by saying, "Where did DoDo hurt you?" She went through the motions once again, eye, head, genitals. Her mother gave us this much confirmation. Joel had been striking Kathie in the head during the past few days.

Shortly afterward, Kathie lost interest in both her knee and the game. As I was getting ready to leave a few minutes later, I noticed Kathie fussing because her hands were sticky from candy I had given her. I took the opportunity to suggest that we spend a few minutes in the sand pile outdoors. Her mother assured me that Kathie would not play with dirt. In the yard I sat beside Kathie and

sifted dirt through my fingers, laughing when my hands got sticky Kathie, now interested, let me pour dirt into her hand Then she stared thoughtfully at her dirty hands "Mummy, too!" she commanded Her mother involuntarily with drew at this request I said, Sure, Mummy, too! and the mother extended her hand while Kathie poured dirt into it We then had a little party each handing lumps of dirt to the other It was the first time Kathie had ever touched dirt

Following this interview, Kathie slept through an entire night for the first time in months

In the seventh visit, I learned of a particularly bad night preceding this visit in which Kathie had awakened about six times requiring prolonged holding The last time she woke up in this sequence she whispered in her mother's ear, 'Mama, pee pee!' as if she were telling a secret Her mother, thinking that she wanted to go to the toilet, took her to the bathroom

Kathie began the interview on her own initiative She brought Dolly and Bee to me and told me to cry for them I picked up the doll and made crying noises. Then Kathie took over

She picked up the doll and imitated the baby's cry I asked What's the matter with Dolly? 'Hoel' Kathie explained She pointed to the doll's foot Both her mother and I were puzzled Kathie was annoyed that I could not understand and kept repeating 'Hoel' Next, Kathie sat the doll straight up on the sofa without support Then Kathie lunged forward and knocked the doll down She grinned up at me I suspected this was identification with Joel and her mother confirmed this Kathie played this game over and over with more and more vehemence Each time Kathie made loud crying noises for the doll Then abruptly she sat the doll up and began to kiss her The kisses were loud and vehement Kathie snuggled her face in the doll's neck and the doll fell over Kathie laughed triumphantly

Now she abandoned the doll and began to stride up and down the room She fell into the role completely and began to take the strides and leaps that so characterize the energetic Joel Suddenly she stopped She walked over to the full length mirror on the door and stared at herself for a long time She lifted up her dress watching her reflection Now she turned and ran She approached a table, reached up to get some Kleenex from the box on it and fastidiously wiped herself between the legs Pee pee she announced Then she tossed the tissue into the fireplace I said Yes Kathie has a pee pee Kathie has a nice pee pee With this Kathie ran over to get more Kleenex and picked up the doll She lifted the doll's dress and wiped her Then she brought the doll to me and said earnestly and worriedly, 'Hoel' She again pointed to the doll's foot. The doll had cloth feet. I was puzzled With real annoyance Kathie picked up her own foot and pointed to her shoe 'Hoel' she said The shoe was 'hoe' Now I understood The doll had no shoe

Now I said Show me Dolly's pee pee Kathie picked up the doll's dress I said it was a nice pee-pee Kathie picked up her own dress. "Kathie has a nice pee pee," I said With this Kathie took another piece of Kleenex and went over to her mother She brought the tissue to the mother's lap making a wiping motion around the genital area I said, 'Yes, Mama has a pee pee just like Kathie's' She

was completely absorbed in this play. Once more she went through the entire sequence, Dolly, Kathie, Mama, and this time added me. I assured her that Kathie was just like Mama, just like "Muh" (her name for me).

Kathie's mother enlightened us further. Yesterday, following the fall that resulted in the skinned knee, Kathie had come into the bathroom earnestly requesting to watch Mama pee pee. She had stayed long, thoughtfully watching her mother. To a question by me, the mother answered that Joel and Kathie frequently go to the bathroom together and Kathie during past months had commented frequently on Joel's penis.

Kathie, meantime, was trying to attract our attention. She had picked up the doll and was loudly imitating crying noises. Kathie kissed the doll tenderly, then she solemnly laid the doll "in bed" and put the Teddy bear beside her. Then Kathie climbed up on the couch beside them, put her face next to the doll's and pretended to sleep. Kathie's mother said that this was what had happened last night. When Kathie had awakened the last time, whispering "pee pee," her mother had taken her to the toilet, put her back in bed with the Teddy bear, and then the exhausted mother put her head down on the pillow beside Kathie and fell asleep.

With the mother's interpolations, we can see how Kathie's pantomime holds together in sequence. She had hurt her knee yesterday. The slight bleeding and pain aroused anxiety. She later went into the bathroom to watch her mother urinate, seeking the answer to a question. All day she was tearful and upset asking comfort for the injured knee. The night was a very bad one, she was reported to have awakened about six times. The last time she whispered "pee pee" to her mother, as if in secret, but the mother had interpreted this as a wish to go to the toilet. The pantomime in which the doll cried because she had no shoe probably tells us that she had awakened in terror following a castration dream. That Kathie had faithfully reported the significant events of the preceding day and night is evidenced in the last sequence in which the mother falls asleep beside the child. We could not have asked for better co-operation from an adult patient.

The sequence in which the doll cries because she has no "hoe" is followed by a pantomime in which Kathie imitates and identifies with Joel. This is interrupted by a sudden trip to the mirror where Kathie inspects herself. The comparison between herself and Joel is the basis for her castration anxiety. But further, recalling the sequence in the preceding interview, she blames Joel for an injury to herself. We recall that "DoDo" had allegedly hit her in the eye, the head, and the genital region.

Following this visit, we had a significant improvement in sleeping. In the four-day interval between interviews, Kathie slept through three nights and had awakened only briefly the fourth night. In the meantime, she had refused to have her bowel movements on the pot and had triumphantly given her signal for "potty" after her pants were soiled. Her mother, as planned, reacted casually to this. The mother had also recorded in her notes that Kathie had tried all day yesterday to get her little rag doll to stand up on the table. When she flopped down limply Kathie would yank her by the hair and fling her on the floor.

In this the eighth interview Kathie began by playing with the rag doll vainly trying to get her to stand up. When unsuccessful she tossed the doll on the floor as her mother had described. Later she picked up the doll, pointed to her foot and said *hurt!* I inspected the doll's foot and said *Not hurt. Dolly is all right. Nice dolly. Dolly has a nice foot. Dolly has a nice pee pee.*

Thinking I could get behind the standing up problem and interpret it more easily in the bathroom I suggested that Dolly has to go toidy. Kathie was enthusiastic, asked me to take Bear and Mummy too, and we all went to the bathroom. She put Dolly on the potty and then put Teddy bear on with her. Now Kathie ordered Mummy and me down on the floor. Her mother and I crouched down and Kathie crouched down with us. Her mother said to me in astonishment that this was what she used to do when she first began to train Kathie. She would squat on the floor to be on a level with Kathie on her nursery chair. But she had not done this for months yet. Kathie remembered!

There was no question about it. Kathie was making encouraging noises for Doll and Bear. Finally she removed them from the potty, pecked inside, congratulated them both like a good mother and carried them back to the living room.

Although I had started this game in order to interpret the wish to stand up, Kathie had her own ideas now. The toilet game became very exciting when she introduced her own variation. Now Kathie without benefit of props like the dolls began to make grunts as if she wanted to go to the toilet. She smiled up at her mother and me, informing us that this was a game and ran ahead to the bathroom. There she sat down on the floor *beside* the nursery chair and began to make the noises which served for bowel movement: *bruurpp*. She pretended now that she was moving her bowels on the floor. I laughed as if this were a big joke and her mother laughed too. Kathie laughed uproariously. Now she arose, took us both by the hand and led us back to the living room. The moment we sat down she said *More!* and began to play the game again. We repeated the game with twelve to fifteen trips to the bathroom. Her interest was unflagging to the end.

Following this first display of defiance we now began to observe a profound struggle in Kathie. In the days that followed her mother reported that before each bowel movement Kathie tensed and cried. She did not ask to be taken to the potty and was *not encouraged to do so*. The urge to defecate and the resistance to defecation in a pot brought about a conflict in relation to soiling herself. When this resulted in her soiling her panties she became even more tearful and whiny. Her mother's casual acceptance of the soiling did not reassure her.

In the following interview I had an opportunity to observe this behavior closely. Kathie initiated the toilet game which we had played in the previous interview. Once again we made our several trips to the bathroom while Kathie sat on the floor beside the nursery chair and grunted as if she were defecating. Around the fourth or fifth trip Kathie suddenly stiffened and began to cry. She called out to her mother that she wanted to "go toidy" and it was obvious that she was no longer playing her game. Her mother walked with her to the

bathroom At the threshold of the bathroom, Kathie began to scream. She sat down on the floor, her body rigid and her fists tightly clenched. Her mother and I stood by offering quiet reassurance. At last the tantrum subsided and in its place came a bitter weeping. Finally Kathie, still crying, asked her mother to pick her up. In her mother's arms, she now began to point toward the hall. We walked out into the hall. Kathie then pointed to the linen closet. Her mother did not understand and Kathie's screaming was renewed. I suggested that she wanted something inside. The closet doors were opened and Kathie began a frenzied pointing. There was an old baby bonnet inside. This was what she wanted. Her mother gave her the bonnet. It was much too small for her, but she perched it absurdly on top of her head and now seemed comforted. "DoDo," she announced with satisfaction. With this, Kathie's mother understood and said that during the last two days Kathie had been snatching Joel's hat from him. The mother had been interested in this "turn about" play, since Joel had always snatched things from Kathie, but had neglected to tell me about it.

Back in the living room, Kathie went directly to the large mirror and inspected herself in the bonnet. She stared at her reflection for several minutes and then burst into heartbreaking sobs. She was inconsolable. Her mother held her in her arms tenderly, but the terrible sobs continued. When she finally began to speak, she repeated over and over, "DoDo Hat. DoDo Hat." Now I told her that DoDo had a hat. And DoDo had a pee pee. He had a pee pee just like Daddy's. DoDo was a boy. Daddy was a boy. Kathie was a girl. She had a pee pee just like Mummy. Just like Muh. Kathie was a girl. Mummy was a girl. Muh was a girl. DoDo was a boy. Daddy was a boy. Kathie listened with earnest attention. "Ted?" she inquired. (Her uncle.) I said that Ted was a boy like Daddy, like DoDo. "Nina?" she said. (Her aunt.) I said that Nina was a girl. Like Mummy. "DoDo?" she asked again. DoDo was a boy like Daddy. "Katie?" Kathie was a girl. Again and again we went over the long list of relatives and friends until their classification was completed. Her crying had ceased and she was playing this as a game with me. Now she took the little hat off her head and ordered me to put it on. I did, laughing. "Muh?" she said. "Muh is a girl just like Kathie." "Mummy!" she said, removing the bonnet from my head and giving it to her mother. Her mother put it on. "Mummy?" said Kathie. "Just like Kathie. Mummy is a girl." She loved the game. We passed the little hat around each trying it on at Kathie's request. From time to time, her mother and I gave her reassurance that she was made just exactly as a little girl should be made and how much we loved her.

As I was leaving that day, in the manner of many an older patient, Kathie brought out the additional necessary piece of information. She brought her doll to me, pointed to the anus and said that this was her "pee pee."

We are now able to see in the toilet play of the last two interviews how the withholding of feces first expressed revenge and defiance of the mother and secondly, fear of loss of the feces equated with penis. This was brought out clearly in the last interview where she played her "defiance" game in good spirits, then made a serious request to go to the toilet. At the threshold of the bathroom, the tantrum came on which finally tapered off to inconsolable sobbing and the

request for the little hat. The hat sequence also gives us the additional clue that her snatching of DoDo's hat was in revenge for his snatching things from her and that somewhere in the months in which DoDo had ruthlessly taken things from her she came to the conclusion that he had taken away her penis.

And now Kathie's nights again became disturbed. For almost a two-week interval between the seventh and tenth interviews Kathie had either slept through the night or wakened only briefly. But following the last reported interview Kathie had three bad nights during each of which she wakened with an anguished cry and had to be comforted.

Just prior to the eleventh session which succeeded the hat interview our work was made easier by the visit of a twenty-two-month-old girl to Kathie's house. Kathie entertained the little girl with all the doll games which we had played together. She also introduced her guest to the toilet game and showed her how she too could enjoy the luxury of disobedience combined with a fraudulent obedience. They spent a happy afternoon sitting beside the nursery chair on the floor making grunting noises. When the two little girls decided that they really had to make pee pee their mothers accompanied them to the bath room where they took turns on the nursery chair. Kathie's mother reported that when Kathie and her friend viewed each other with pants down a profound silence ensued. They stared at each other long and searchingly. Sometime afterward the girls were playing in Kathie's room when the mothers heard loud giggling and noises. When they peeked in to see what was going on they found the two tiny girls with a drawer full of hats and bonnets on the floor. They were trying on hats, preening before the mirror and admiring each other noisily.

Kathie's interest in sex differences was now expressed in a variety of games. Thus she would proudly identify and discriminate between boys and girls, men and women in picture books and magazines. She began to take pleasure in certain articles of clothing which were just like Mummy's. Nevertheless Kathie's conflict about soiling became severe. In spite of her mother's reassurance each bowel movement brought on a tensing and cries of fear. She would stand stiffly as she had her movement in her pants, crying out pathetically to her mother. When her mother then asked if she wanted the potty she would scream in protest. On the morning of the eleventh interview Kathie went through the same procedure then hit upon a brilliant compromise. She set off for the bathroom alone, ordered her mother to keep out and closed the door behind her. Sometime later she called her mother. Her mother found her seated on the nursery chair seemingly quite pleased with herself. The lid of the nursery chair was down and Kathie was sitting on top. She had made her bowel movement in her panties while seated on the closed chair. When I came to visit later in the day Kathie repeated the performance for my benefit. However when her mother later said casually that she would give her clean pants Kathie refused vehemently. We decided to let it go for awhile. Meanwhile I assured Kathie that she would get a new B.M. every day but even with this interpretation she refused to have her panties changed for the rest of that hour.

Within the week that followed Kathie's anxiety about defecation diminished.

markedly throughout the day but she continued to wake briefly at night crying out of fear. In the twelfth interview when I tried to create play situations in which to work through some of this material she ignored me completely. She even refused to play her favorite toilet games. She spent a little time playing in the sand pile with me and was thoroughly spontaneous. There was no longer the fastidious withdrawal from dirt and she even permitted herself a solemn ritual in which she squatted above a little mound of sand and urinated on it. In the following visit I introduced plastalene and she delighted in games in which the dolls made B M's. Yet as soon as I placed the dolls in bed she withdrew her attention. When I asked why the dolly was crying she answered with a phrase which she had recently acquired: I dunno!

The brief night waking indicated that there was obviously some residual anxiety which had not been worked through. All evidence pointed to the fact that this elusive fragment belonged to the anal material. The fact that she still disliked having her panties changed after a bowel movement provided one clue. Also I observed that although she now defecated in her panties with cheerful unconcern she would not permit me to let the doll do likewise. And finally she would not play games in which the dolls woke up at night. From this I tentatively concluded that the fear of soiling was still the basis of the night waking.

In the thirteenth visit, when she again persistently evaded the doll who woke up crying I suggested casually that maybe the dolly was afraid that she would make a B M in bed. I at first ignored me. I pursued the play myself put a piece of plastalene in the doll bed placed the doll on top and caused her to cry. Then I picked up the doll and remarked casually on the B M in bed and reassured the doll that it was all right. Kathie stood by tensely. Suddenly she picked up the doll and ran over to her mother. Mama hold! she cried anxiously. Her mother held the doll as Kathie directed and uttered comforting words to it. I then told Kathie that the dolly was afraid to make a B M in bed because she thought her mother would be angry. Her mama would not be angry. And the dolly did not like to see her B M go away. But she would get another one every day. Kathie listened intently then backed away from the scene.

A few moments later she became absorbed in play with her toy dishes and finally called her mother and me over to sit at the little table. She had picked up all the little pieces of plastalene which we had used in the defecation games and these were tastefully arranged on the little dishes with a fork and knife alongside. At first she encouraged us to eat with the words of a mother: Good! she assured us. Yum Yum! We pretended to eat with deep concentration.

More yumyum! she would say pouring a little milk from a pitcher onto the plastalene marbles. But soon the tea party fell into great disorder. She became noticeably irritable, ordered her mother and me around, told us to sit here, no sit there, no, not there! Then came tears. She wanted something on top of her chest of drawers. No, she did not want that. She wanted this. No, she didn't want that. And finally she screamed her frustration and wrath at everything and every one in the room and ended by sitting on the floor sobbing miserably. When it was time for me to leave she was still in a bad mood and would not be comforted.

That night Kathie slept through without waking In fact it should be said here that this episode marked the end of the anxiety waking

It then appears that when the nocturnal anxiety returned on the anal level two components could be discerned. One was the fear of loss of the mother's love for soiling. The other was fear of loss of feces as equated with penis. At the same time there was the desire to please the mother through being a big girl and defecating in the pot. The resulting conflict is dramatically brought forth in the interview reported. Thus with my two fold interpretation of the fear of mother's disapproval for soiling and the fear of losing the feces she reacted at first with a play in which she gave plastalene feces to her mother and me in the tea party. The form of this play in which she gives the feces as food probably reveals her own wish to retain the feces through oral incorporation. But then we note the sudden swing in mood the cacaphony of affects the wanting and not wanting which reveal the strength of the ambivalent tendencies.

In subsequent interviews we worked over certain details such as the bedtime rituals the reluctance to have panties changed and other such matters. Beyond this there was no further need for help from me. The night waking ceased and there has been no return of the sleep disturbance in the two and a half years which have elapsed. There has been a close follow up during this period.

Treatment brought about marked character changes in Kathie. It should be noted that even after the first month as soon as the anxiety in relation to soiling diminished we began to see rapid changes. Her vocabulary increased she became spontaneous and friendly and played for long hours without needing her mother. At the close of treatment she had actually advanced beyond her age level in vocabulary in play and in social relations. She proved herself competent in dealing with Joel and learned to retaliate actively when he teased or snatched things from her. She became gay and animated and spontaneously friendly and affectionate.

In the case of Kathie then we see the evolution of a sleep disturbance from the early stages of anxiety to a complex symptom formation at eighteen months. Several features of this case are of special interest here. The conditions which brought about the night waking at thirteen months the later conflict in relation to soiling and the appearance of castration anxiety represent a sequence in which anxiety accrued on each successive level sweeping each new libidinal phase into its wake with devastating results.

The effects of the early traumatic situation need little elaboration here. We can see how the attacks of Joel beginning at thirteen months produced each time a state of helplessness and terror. The mother's uncertain handling of these situations at the beginning must certainly have contributed to the anxiety since a child of this age must rely in a large measure upon his mother to defend him against danger. It should be noted that these attacks differed from the type we observed at eighteen months in which erotic play ended in the biting which was so painful to the child.

At this stage, thirteen months, the attacks are reported to be frankly hostile and malicious. The erotic factor with its sadistic intent is said to be a later development. In terms of our earlier discussion it seems probable that the traumatic character of these repeated attacks produced a sleep disturbance which, in its earliest form, was a night waking following a dream in which the trauma was reproduced.

At fourteen months, toilet training was introduced. The child's communications to us in treatment establish the fact that bowel control was achieved under the pressure of great anxiety. In her toilet games, we see the refusal to defecate in the pot and at the same time, fear of soiling. Yet, from the mother's history we learn that this training was accomplished without any visible resistance from the child. In many cases of emotional disturbance during the second year, we receive such puzzling reports of an uneventful training period. Our first reaction is one of suspicion. Yet after studying many such cases I am inclined to believe that this is actually so. The fact can only be explained on the basis that the child produces this absolute obedience to the demands for cleanliness under the influence of anxiety and what is perceived as a real danger of losing the mother's love.

We observe, then, that the sleep disturbance became more severe in the period of toilet training in spite of the fact that the mother's handling of the attacks of Joel resulted in curbing these aggressions and diminishing the objective danger. This suggests, then, that the earlier trauma continued to exert its influence in the child's anticipation of pain, helplessness and danger produced by the failure to comply with the mother's demands. It is as if the ego, threatened from without and vulnerable at all points, engages in a treaty with a strong ally whose good favor must be carried at the expense of impoverishment of internal resources.

On this level the meaning of the sleep disturbance is revealed in our material. The last analyzed fragment of this layer which had bound the child to her symptom was the fear of soiling the bed in her sleep. From this we deduce that this must have been the original fear which followed upon the introduction of toilet training. As an additional factor, we have fear of loss of feces which plays such a prominent role during this period.

In the third phase of the sleep disturbance we see the effects of Joel's erotic play and the way in which this premature sexual excitation brought on a further development in the course of the anxiety. The little girl was convinced that her penis had been taken away. There are two factors in Joel's erotic play which require investigation. The first is into the nature of the stimulation which brought about a steadily mounting excitement. This excitement remained undischarged at its highest point of pleasure when the act ended in biting Kathie and the infantile love making ended.

in the small child's screams. We know that failure of discharge of sexual excitation may, in itself, bring about anxiety. When we add to this the fact that these novel and highly pleasurable sensations in the genital region necessarily brought about a high valuation of the sexual organ in the little girl, we can see how the groundwork was laid for a new fear. Since Kathie had had many opportunities to observe Joel's penis, we assume that her own genital differences became the source of anxiety, when pleasurable tensions brought about the importance of this zone and when the consequence of such pleasure was pain and injury. From this she reached the conclusion which she reported to us, that "DoDo" had injured her genitals.

From our material we were able to see how the sleep disturbance in the later stages followed anxiety dreams in which fear of genital injury appeared. From the mother's reports and the play sequence of the seventh visit, we are able to understand that such a dream had caused her to waken in alarm. "Mama, pee-pee!" We recall that this particularly bad night had followed the injury to the knee, and the later observation of the mother in the toilet. In her play which recapitulated the whole sequence and included the night and the night waking, we received a report of the dolly who had no shoe and when this was interpreted, Kathie completed her report of the events of the night to the last detail which included the mother going to sleep beside the baby.

In this early neurosis, we can follow the development from the first manifestations of anxiety and the night waking through a complicated course in which the symptom was strengthened and elaborated on successive levels of libidinal development. The original trauma in which injury brought with it the fear of losing the mother (a fear made more urgent by the presence of danger) exerted its influence in the later phase of the illness. The anal material revealed fear of loss of the object both in regard to the mother and feces. This fear produced the conflict about soiling which played a prominent role in the sleep disturbance. Subsequently the fear of injury and fear of a genital loss combined their forces in typical fashion so that the child concluded that Joel had injured her genitals and had taken away her penis. In this way, external forces reinforced the basic fears throughout, and the night waking, derived from the traumatic situation, continued including each of the later phases, in its course.

SUMMARY

To summarize our findings regarding the sleep disturbance of the second year:

The night waking which is regarded as typical for this age by re-

searchists in child development appears in both its moderate and severe forms. In any case its characteristic appearance during the second year may be attributed to those developmental tasks and problems of this age which produce anxiety in the child and hence make heavy demands upon the immature ego which strives toward control of the painful stimuli. Night waking, in the cases studied, followed an anxiety dream.

It was seen that in each of the cases reviewed, the night waking first appeared in relation to a traumatic event. The dream mechanism in the early stages of such sleep disturbances is likened to that of the traumatic neuroses in which the dreamer is brought back to the scene of the trauma and the dream work supplies the conditions of apprehension and anticipation which had failed in their protective functions at the time of the original event. The character of the dream conforms to the child's tendency at this age to gain mastery through repetition.

The conflicts of the anal period play an important role in symptoms of sleep disturbance as well as the other symptoms so common at this age. When pleasure in soiling must be relinquished for fear of loss of the mother's love, the conflicting tendencies may produce another type of anxiety dream which results in interruption of sleep. Here the fear of soiling in sleep breaks through. In two such cases it was seen that the wish to soil was manifest in the dream (from our deductions) but fear of loss of the mother exerted a more potent influence at the critical moment, so that the wish fulfilling function of the dream failed and anxiety broke through, resulting in the interruption of sleep.

Further, it is noted, that failure to master anxiety on one developmental level will result in a progressive course of the symptom so that each successive phase of libidinal development comes under the influence of the original trauma and adds its own characteristics to the illness. In one case it was possible to follow the development of the symptom from its origins in a traumatic situation through the anal period and finally the beginnings of a prematurely induced castration anxiety.

The study suggests that an understanding of the sleep disturbances of early childhood may provide us with further prophylactic measures. The early detection of serious sleep disturbances will still permit simple environmental measures which can secure good results in most cases. The more evolved symptoms require direct therapy. And for the common varieties of night waking during the second year, there is every reason to believe that if we understand the child's activity more fully as well as his devices for mastering the typical traumata, we can improve our nursery techniques and through educational measures reduce the incidence of sleep disturbance. There is great danger that our present techniques of handling the very young child encourage passivity at a time when he

needs all of our help in taking the active position in relation to the dangers which threaten him. By this I do not mean, of course, that we foster a spartan independence, but rather that we understand his behavior and its aims in this critical year and support these tendencies, helping him to abreact through the ancient devices of the nursery.

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SOME VARIANTS IN MORAL TRAINING OF CHILDREN

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This paper will present some hypotheses suggested by the findings of a recent research project. The statements which follow are not assumed to have been proved, but are put forward as useful hypotheses for further investigation. The data which suggested these hypotheses were mainly provided by interviews with parents and children of various backgrounds about their moral ideas.¹ I have attempted to formulate possible interconnections among these conscious moral ideas as well as relations between these ideas and less conscious feelings.

In discussing various moral ideas, I shall speak of Czech parents and children, Chinese parents and children, and parents and children of other cultural origins. It is not assumed that any of the psychological relations discussed here is peculiar to one particular culture. Rather it is taken for granted that any of these psychological possibilities may occur in individuals in any cultural setting. These hypotheses are thus applicable to individual case material and should be further verified in such material.

Parents usually do not begin to apply conscious moral conceptions and disciplinary techniques to their children from the moment of birth. An interval of varying length elapses before the conscious moral code of the parents and its sanctions are applied. Speculations about very early experiences of the infant have suggested that he may feel every deprivation imposed by the mother as a punishment for his destructive impulses. It is equally possible to assume that this is a retrospective transformation of early impressions in conformity with later experiences. However we may reconstruct the feelings of the infant, from the parents' side certain early

1 This research was done as part of the Columbia University project *Research in Contemporary Cultures* inaugurated by the late Professor Ruth Benedict in 1947 under a grant from the Office of Naval Research and reproduction in whole or in part is to be permitted for any purpose of the United States Government. A special group worked on a cross-cultural study of child training interviewing parents of various origins (mainly Chinese, Czech, Eastern European, Jewish, and Syrian) and their American-born children between the ages of 6 and 12. Families were interviewed by researchers of their own cultural background. The author is indebted to the work of Mrs. Ching Ho Liu, Mrs. Edith Lauer, Miss Naomi Chaitman, and Dr. and Mrs. Stephan Toma in this connection. Other materials from the larger research project were also freely drawn upon.

deprivations which they impose are consciously distinguished from later deprivations which are introduced as moral sanctions. Thus the mother who does not feed her crying infant because she is adhering to a schedule or who later weans the child from the breast or the bottle is consciously behaving in a different way from that in which she may behave later on when she deprives the child of candy or some other desired object because he has been naughty. In this sense we may speak of an early premoral phase in the parent child relations.

The premoral, or (as we may also call them) nonmoralized, relations appear as such from the parents' point of view, we are not at present able to say what differential impact parental treatment has on the child depending on whether it is consciously felt by the parents as morally justified. While premoral feelings are apt to be most prominent in early phases of parent child relations, the term is not intended in an exclusively temporal sense, premoral maternal attitudes may continue side by side with later moralized behavior towards the child. We should also not overlook the case where the mother's relation to her child may have a moralized quality from the moment of the child's birth or even before.

The parents probably feel their moral relations with the child as different from, and disconnected with, the premoral relations. However, we may take it for granted that there are close connections between the two. Certain aspects of the premoral relations may serve as models for the moral relations. Differences in moral ideas and sanctions may be related to different premoral experiences.

We may start from the consciously moralized behavior of the parents and proceed to speculate about its antecedents. Punishment is an incident in the moral drama of parents and children which may be enacted in a variety of ways. The form of punishment, its tools, the time and place and agent of punishment, the emotional reactions of the punisher and the punished admit of many variations. Material from different cultures can illustrate the range of variations as can material from various types of character and neurosis. If we consider the tools of punishment, we find for instance that Czech mothers whom we interviewed consider it traditional to use (or threaten to use) the wooden kitchen spoon for spanking their children. This brings to mind the stock implement for spanking supposedly preferred by American mothers, namely, the hairbrush. We may ask what differences in the mother child relation are expressed in one mother's choosing to punish with a spoon and another with a hairbrush. What premoral situations are suggested by these implements, both of which have other uses? The kitchen spoon evokes a feeding situation and specifically the preparation and giving of solid food. The hairbrush suggests the mother's concern to make the child clean and neat and her efforts

to elicit from him responsiveness to these demands. Thus our first tentative guess is that something in the mother-child relation having to do with the giving of solid food is repeated in the choice of the kitchen spoon as the spanking instrument, while where the hairbrush is chosen the antecedent situation is one of cleanliness training. The guess that Czech mothers tend to model punishment on something in the feeding situation (that is, something to do with giving and withholding) seems to be supported by further information. The Czech mothers to whom we spoke, who all knew about the kitchen spoon as a traditional punishment tool, but who were inclined to say that they themselves merely threaten to use it, tended to prefer as an actual punishment the withholding of something which the child very much wants.

Let us see whether a like connection suggests itself in other choices of means of punishment. Our Syrian and pre-Soviet Russian sources portrayed occasions of punishment in which children were beaten with a whip or belt which wrapped itself around the body, and where the child might be tied down before being whipped. If we look for a premoral antecedent to this, we find that in both cultures the swaddling of infants seems to be prominent, that is, something is wrapped around the body and the child is immobilized.

A variety of modes of punishment is of course chosen within any given culture, as also within any particular family. According to Syrian informants the pinching of the ear is another preferred Syrian form of punishment. School teachers have special metal implements with which to pinch the ears of their pupils. The manifest rationale for this attack on the ear is that the child has not listened to the words of his mentor: the punishment is directed against the refractory organ. The presumable relation to an earlier model is somewhat complicated in this case. A characteristic style of nursing in Syrian culture seems to be for the mother to bend over the infant who is bound down in his cradle and to thrust her nipple into his mouth. Even the older child may have pieces of food thrust into his mouth (and the same procedure is practiced with guests). The relation between the immobilized infant into whose mouth the breast is thrust and the school child who is required to receive with equal docility the words of the teacher is indicated by explicit formulations. The child is supposed to receive his character from his mother's milk. Of the older child who is resistant to the moral teachings of his elders it is said: his head is dry. Thus words replace milk and the ear replaces the mouth as the orifice through which the character-formative stream is to be admitted. The punitive attack on the ear is related to a prepunitive situation via a displacement from the mouth to the ear.

The foregoing examples have suggested that punishments tend to re-

peat some earlier phase in parent child relations not only in the choice of implements but also (where the punishment is corporeal) in the part of the body to which the punishment is applied. A further illustration indicates a similar connection in the attitudes expressed in the punishment situation. A Chinese informant tells how her little brother at the age of four, having done something wrong spontaneously took down his trousers and bent over a stool waiting for his mother to come and spank him. The other children ran to tell the mother that brother is waiting. A contrasting picture is presented in an account by a mother of German origin when she was threatening to spank her little boy of about the same age, he put his hands over his buttocks and shouted *It's mine, don't you dare touch it*. Punishment which focuses on the buttocks may be supposed to be related to antecedent experiences in toilet training. In the two instances cited, differences in the method of toilet training seem to correspond to the different attitudes expressed by the children towards spanking. The German mother has toilet trained her child by demanding that he voluntarily submit a function of his to her control: the issue of whether it is his or hers was contested. The little boy repeats apropos of the spanking the sense of protest which he has felt earlier about his excretory functions. The Chinese mother has begun toilet training her child between one and three months and has not expected that he could voluntarily do what she asked or *obstinately resist her*. *She has picked him up at a likely moment* so that the child's excretory activities almost from the first are associated with the mother's presence and may be felt to be hers as much as they are his. In offering his buttocks for the spanking the little boy seems to be expressing *it is yours*—just as the other child asserts the opposite.

If we suppose that punishment repeats an earlier, premoral situation, we must ask what could be motivations for this repetition. A preliminary hypothesis would be the following. In the early care of the child the mother of necessity imposes numerous deprivations. Her empathy with the child re-evokes in her (probably mainly unconsciously) the feelings of rage and resentment which she felt towards her own mother in similar circumstances and which she now feels are directed towards her by her own child. If later when the child has been bad she symbolically repeats the earlier deprivations in the guise of punishment she communicates to the child in effect that it is his own badness which has provoked the deprivations and requires that he redirect his blame of her into self blame. As a result the earlier deprivations are reinterpreted or, insofar as the child has a spontaneous tendency to feel that the original deprivations were punishments for his bad impulses this feeling is now confirmed. Hence punishment may tend to re-enact those early experiences which were felt (presumably by both mother and child) to have had a strong de-

privational impact on the child. Where this is the case for weaning or the introduction of solid food, a favored punishment would be likely to be withholding, and the spoon might become an instrument of punishment. Where toilet training has been a major focus of interference with impulse, the related punishment which in a moralized way attacks the same body area would be spanking. Where early interference with motor activity through swaddling has had a strong privational impact, the related punishment may be a renewed immobilization as the child is bound and a lashing of the body in which the whip replaces the swaddling bands.² Of course, as we have already remarked, a variety of punishments is usually chosen in any particular family or group which would then commemorate a variety of early deprivations.

We might guess that, other things being equal, the prominence of a particular punishment device would tend to be proportional to the intensity of the early deprivation repeated in it. Where deprivations in a certain area tended to be minimal—as seems to be the case with our Chinese subjects in respect to oral satisfactions—there would be little or no reference to this area in chosen punishments. Thus our Chinese parents showed very little inclination to withhold food or any other desired thing as a punishment. We might suppose that the mother is loath to impose as punishment what she did not previously wish to impose as a premoral deprivation. In other words, in the area where the mother is from the start most gratifying she tends to remain so.

While this hypothesis enables us to connect various phenomena in a meaningful way, it raises a number of further questions, which we probably cannot answer here. We do not know why in some cases one or another early deprivation has a particularly strong impact, or why, where this impact seems related to specific details of maternal handling (in the manner of weaning, toilet training, etc.), the mother (or group of mothers) should choose these procedures. Moreover we have not indicated how the father's disciplinary role may be related to the moral and premoral mother-child relations. Even in respect to the mother, there is evidence to suggest that there are other (though not necessarily conflicting) factors operative in the development of her moral relations with the child. Thus it seems possible that one of the circumstances relevant to the mother's choice of punishment is what she finds most difficult or painful in the care or training of the child. These areas of difficulty may be individually idiosyncratic or—as in the instances which we have been considering, possibly traditionally regular. Suppose for instance, that mothers find cook-

2. Whether swaddling has a privational impact has been questioned by Phyllis Greenacre(3). Ruth Benedict(1) has suggested that swaddling may have a variable impact depending on the intent of the swaddler.

ing especially burdensome (which may be a stock way of regarding this function in a particular culture) When their children are 'bad,' the righteous resentment of these mothers may be reinforced by the accumulated (though nonmoralized) annoyance related to their cooking duties. Such a factor may overdetermine the appearance of the cooking spoon in the punishment situation, where it may represent a reproach (after all that I have done for you!) and also a reversal of hardships (what the child has imposed upon the mother is now turned against the child) In the case of a masochistic mother the re enactment or re evocation in punishment of the pains which the child causes her may have a (probably unconsciously) gratifying effect as well This is illustrated in the behavior of some of our Jewish mothers who use as their most severe punishment a more or less prolonged refusal to speak to the child Among the motivations of this probably highly overdetermined behavior, the following is relevant in the present connection These Jewish mothers are apt to reproach their children with having damaged and weakened them through the ordeal of childbirth, the depletion of nursing, etc There is some evidence to suggest that this suffering imposed by the child, and the fantasy of being destroyed by the child, is a source of strong gratification to the mother though it may only be expressed in complaints and conscious dysphoria When the mother, injured yet again by the child's badness, refuses to speak, she is behaving as if dead, that is acting out the fantasy that the child has destroyed her

This further hypothesis, that the mother re evokes in punishment what she feels as the greatest hardships that the child imposes on her, is quite compatible with the previous hypothesis that punishment repeats what to the child have been major early deprivations It seems likely that what the mother experiences as the greatest hardship in relation to the child may be experienced by the child at the same time as the greatest deprivation The way the mother handles him in what to her is the least enjoyable aspect of their relation may very well convey to him negative and distressing feelings

We have so far taken the situation of punishment as an illustration of possible connections between moral and premoral parent-child relations Let us now proceed to consider a larger range of details, including together with punishment, reward and other moral actions and ideas, and let us see whether these may be systematically interrelated and also point to premoral prototypes

We may take as illustrative some of the material obtained in our interviews with Czech mothers and children One of the distinctive features of the disciplinary technique of these mothers is their tendency to combine reward and punishment A promised reward is apt to be in

extricably involved with a threatened punishment. Thus, as one mother describes her procedure, she promises her children long in advance that if they are good they will get some present or outing. In the intervening time whenever they are bad she threatens to withhold it. Thus the same object figures in both a reward and a punishment context, according to whether the mother will give it or withhold it. This contrasts with parental procedures in which rewards and punishments are mutually independent, where the child is separately rewarded for good behavior and punished for bad. Thus our Chinese parents tend to say that they spank their children when they are bad and may buy them new clothes when they have been good. The tendency of our Czech parents to mingle reward and punishment was reflected also in what their children told us. Two sisters, aged nine and five, agreed that the best thing that could happen to them was to break a leg: then they wouldn't have to go to school. The fantasy of being exempted from school without any attendant penalty was apparently not accessible to them. (In this instance, another factor seems also to be operative, namely, the need to pay in advance for a forbidden gratification.)

The tendency for reward and punishment to be mutually involved is further illustrated in the way in which our Czech parents are apt to praise their children. Praise frequently carries also a connotation of blame. When a child has behaved well on a visit to friends of the parents, the father or mother may say: "You see how well you can behave!" According to these words of praise the child has, as it were, unguardedly behaved well on this occasion and thus supplied ammunition in support of the parents' argument that he could behave well at other times. The commendation for this instance of good behavior reminds the child of less good behavior on other occasions. In a similar way a mother asks her little girl: "What did I say when we were visiting last Saturday and you behaved so nicely?" The little girl replies: "That you were proud of me." The mother continues, "Yes, but I have to say more often, 'Don't do that, I will have to be ashamed of you.'" These mothers also show a similar tendency in the opposite direction, starting with criticism and shifting to commendation. One mother says that children should obey, then immediately qualifies this by saying, "I mean within reason." (This group of parents tend to qualify the demand for obedience with "I mean seventy-five percent of the time," or "Of course, I would not like a child not to show any opposition.") The mother continues that she has, of course, still to remind her children to do many things. However, "I have to say it myself—they are really good children." This is again followed by her calling to mind another cause for reproach: "I tell them that they

should not waste food—this is something I really cannot stand ' ³ A combined or alternating reward and punishment value seems also to attach to explanations as used by our Czech parents. Explanation is a frequently cited disciplinary device, but is also referred to as a positive form of parent child relation as when a mother says that a father is needed to explain things to his sons.

The tendency for a positive expression to be followed by a qualifying negative one and conversely appears not only in praising and blaming children, but in other contexts as well. This tendency is manifestly explained as a fear of exaggeration. A positive statement seems to call to mind at once negative, nonconfirming instances and so to be one sided and inaccurate, when the necessary negative points have been expressed, positive feelings again emerge and so on. The need to avoid exaggeration does not seem adequately to account for this oscillation between positive and negative feelings, since exaggeration may also be avoided by cautious phrasing or consistent understatement. What we see here is rather a continuous giving (the positive statement), taking back (negative qualifications), restoration (renewed positive expressions) and so on. Such a series of alternate withholding and giving is illustrated in the following statement of one mother apropos of adult misbehavior: I have no sympathy for a bum or a drunk. I want to help people—though I'm very poor. But a drunk or a bum—I don't say no one should help them. But somebody who has more money, or an agency. I would even take a seventh child into my house.

This pervasive tendency, of which the interlocking of reward and punishment is an instance, may be related to a premoral phase in the mother child relation, namely the feeding situation, and particularly the preparation of solid food. As we would reconstruct this situation, the

3 This close association or rapid alternation of reward and punishment may have the further function of insuring the moderation of punishment. We may advance the hypothesis that where there is little apparent apprehension about the destructiveness of punishment there is a fusion of sexual and destructive impulses and conversely where precautions against such destructive effects are introduced these impulses are relatively diffused. Where there is a fear of an undiluted break through of the negative sector of ambivalence in punishment that is where the negative sector is delibidimized the need to justify punishment seems to be strong. Such justification seemed to have been successfully conveyed to children of both Jewish and Chinese groups whom we interviewed.

We might advance here the concepts of "additive and subtractive mixing" of reward and punishment—additive where the emotional impact is heightened subtractive where it is reduced. The fusion of impulses in punishment as described by some of the Syrian informants would be an instance of additive mixture. In the case of our Czech subjects the effect of combined reward and punishment would seem rather to be subtractive particularly in spoiling the pleasure in the reward. This brings us back again to the point that we do not have here a fusion of impulses but rather diffused impulses which continually interfere with each other.

mother feels resentful at the imposition of having to cook for the family, she counteracts this resentment with conscientious and exhausting efforts in the kitchen, which then evoke more resentment, which in turn is atoned for by further efforts. An episode in a recently published Czech children's story (*Zuzanka Discovers the World* by Hlena Chvojkova, Prague, 1946) seems to confirm this reconstruction. A princess offers to cook dinner all by herself for her prince and sends the servants away. However, when she goes to the kitchen she finds that there is only one egg, and in her unskillfulness she drops it on the floor. She has nothing to feed her prince and she weeps thinking how she would even give her heart for him. At this her heart flies out of her breast and into the frying pan. She cooks it and serves it to the prince for dinner. Afterwards, however, she is very mean to him—because she has no heart.

Our Czech mothers seem perpetually to complicate their cooking tasks while at the same time they manage to precipitate reproaches from their children about the food. Each member of the family is encouraged to develop special idiosyncrasies of taste, so that sometimes the mother is cooking the same thing in as many different ways as there are members of the household. However, in some cases the favorite dishes of one member of the family or another must be served in alternation. This becomes the occasion for reproaches: You have cooked daddy's favorite dish twice since you have cooked mine—and so on. In the food-giving situation, the mother's withholding tendencies are not overt but can only be inferred from what appears to be a reaction-formative overpreoccupation with and complication of cooking, by the mother's provoking reproaches from her children for insufficient giving (which may be an indirect way in which the mother achieves the expression of her own self-reproaches) and by such fantasies as that of the princess with her heart.

Recollections of these mothers about their own mothers tend to express a reproach that their mothers did not give them enough. Such reproaches are apt to be expressed with the characteristic qualifications, so that the mother who is described seems partly giving and partly withholding, and the daughter who describes her repeats the same behavior. Thus a mother will say that her own mother was a very good mother, only she did not show enough affection; she really loved the child, only she did not understand that sometimes you must show appreciation and so on. Another mother will say: My mother did not have much time for us, she was always busy with the housework. Shortly afterwards she makes up for this reproach by saying that sometimes she can even understand and sympathize with the mothers one reads about in the newspapers who abandon their children; perhaps it was too much for them, with maybe five children and the husband in the hospital or drunk, etc.

These mothers also express strivings for autonomy so that one becomes the source of gratification for oneself and is not dependent on others who may be disappointing. These autonomy strivings are indicated as having both good and bad potentialities. One may become a drunkard which is one of the worst things or one may become an omnivorous reader which is one of the best. One mother quotes her own mother as saying: "A good book never disappoints you." An 11 year old son of one of these mothers responds to a TAT card which pictures a woman looking into a room. She is looking for some person or maybe for a book.

It is a truism that parents tend to repeat the behavior of their own parents. However the mechanisms involved in such repetition are it would seem far from simple. Assuming that our Czech mothers repeat an oscillation between withholding and giving which they felt in their own mothers we might find a variety of motivations which combine to keep this oscillation going. The mother's identification with her own mother's withholding might tend to evoke her own resentments as a child which she now attributes to her children and wants to avoid her own pity for herself as a child which she now directs towards her children and her reproaches against her mother which arouse guilt and evoke the alternate image of the giving mother (my mother was a good mother she really loved me). These and probably other feelings impel the

mother from withholding to giving. But the grudgingness which she has felt in giving to her own mother evoked by her mother's insufficient giving to her and her displacement to her children of what she felt were unfair demands of her mother impel her again into a withholding position. Some of the alternations of feelings about giving as a mother shifts from thoughts of her parents to thoughts of her children are suggested in the following remarks. "Children have no obligation. They certainly should obey but they have nothing to do with their coming so it's up to you to do your share and children have no obligation. Here the mother is probably expressing mainly her feelings towards her own parents. Shortly afterwards when asked what is the worst thing children can do she says: "If they only take without thought. When they make a big fuss when they can't get something they want. We would guess that she is now thinking more of her children. However, she quickly again shifts the balance of blame and adds: "But this is often the fault of the parents."

Let us now return to our earlier general proposition about a possible relation between the mother's moral and premoral handling of the child and see how this can be applied here. According to our hypothetical reconstruction of these mothers' behavior in regard to feeding a conflict over giving and withholding is expressed mainly through an intensified expression of the positive sector, which serves to repress the resentment

for having to give what is felt to be too much (the meanness of the princess after having cooked her heart) and the indirect expression of doubts whether the mother gives enough via the complaints of the children which, despite all her apparent efforts, she manages to evoke. If we turn to the moral relation in reward and punishment, praise and blame, we find that the withholding tendency is much more outspoken. The intimate involvement of giving and withholding impulses which we suspected in the feeding situation is here clearly dramatized. Rewards are held out to the child as something which the mother alternately promises to give and threatens to withhold. Words of praise are half taken back again by counteracting expressions of criticism.

We are now led to a possible refinement of our general hypothesis about the relationship of moral to premoral maternal behavior. In the premoral relation the mother may tend to repress or otherwise interfere with her impulses of annoyance towards the child. These accumulate and are able to find "justified" expression when the child is bad.⁴ Thus our Czech mothers are able to express in the sphere of reward and punishment the withholding component of the giving-withholding complex which they restrain in the feeding situation. A similar observation can be made in the case of our Chinese mothers who show so much patience and tolerance in toilet training which they begin so early and in which they accept slow progress and late completion with seeming equanimity. However, when the child is naughty, the little buttocks are beaten freely and frequently. We may leave it unsettled here whether the mother's greater restraint in expression of negative feelings in premoral relations is the general rule or observable in certain cases only. We may note in this connection that there are mothers who use spanking as a major punishment who are much less restrained in the expression of disgust, impatience etc., in connection with toilet training than our Chinese mothers seem to be.

Let us now turn to other moral variables. We may consider some of the adult beliefs about the probable results of meritorious behavior or its opposite in this life. We may take a type of behavior which is widely regarded as meritorious, namely effort. What relations between exerting

4 The converse of the mother's feeling seems to be expressed in the fantasy of an eleven year-old boy of a Czech family. Asked to tell a story of a good boy, he tells about a film he has seen: "It was in the middle ages and there was a boy, he robbed bakeries. The bakers were chasing him but they did not get him." The interviewer thinking that he had misunderstood and told about a bad boy asked whether he wanted now to tell a story of a good boy. The child said: "But this was a story of a good boy. You see this was the middle ages and then the bakers were very rich and the boys were very poor and had to work hard." Thus in the boy's fantasy where food is withheld the child's taking is justified (becomes good). This is the reverse of the mother's feeling: when the child is bad, withholding is justified.

one's utmost efforts and the occurrence of success are supposed to exist? Roughly, there are four possible combinations: effort and success, effort and no success, no effort and success, no effort and no success. Of course, an individual or group may regard one or both of these variables as of no value and accordingly be unconcerned with their probable relations. Where effort and success are regarded as morally relevant, it is possible to stress one or another of their alternative relations. There may be, for instance, strong belief in the efficacy and irresistible force of effort, that is, the combination of effort and success may be emphasized: if one tries hard enough one will succeed. The converse may also be held: if one has not succeeded it is a sign that one has not tried hard enough. This would seem to correspond to one type of older American moral ideology. On the other hand, it is possible to stress the other pair of alternatives. Success may seem to be mainly a result of chance. One may regard the successful with doubts as to whether they have made any effort commensurate with their success and award the greatest praise to those who without succeeding have exerted themselves the most strenuously. This seems to be maintained by some of the Czechs whom we have interviewed.

If we examine this position a little further we find that it seems to imply a higher valuation on effort than on success. A Czech woman tells us how badly her father felt when her Gymnasium teacher told him: "Your daughter is doing excellent work, but we know that she is preparing her homework a few minutes before class." The father, reproaching the girl, told her how much he would have preferred to hear that she was making a less brilliant record but had tried harder. The idea of the combination of effort and success is not prominent here. Success tends to appear as undeserved, while great effort is imagined as combined with lesser success. We somehow get the impression that it is not only the demonstration of effort but also the lack of success which has positive value.

To consider an early experience in the life of the child in which effort and success and their opposites occur, we may return again to toilet training. If we consider what would correspond to the combination of effort and no success, it would be the situation where the child gives demonstrations of trying without producing anything. If we ask further why this situation might be highly valued, we would guess that in this case the child wishes to frustrate the mother, or rather to give and withhold at the same time, thus he gives his effort but withholds the feces. This might then be a prototype of the moral situation favored by our Czech informants. Relating this to what we said earlier about the conflict over the giving and withholding of food which we ascribed to our Czech mothers, we might infer that in toilet training the child responds in a

similar way about giving and withholding of excretion. The greatest feeling of gratification would attach to the instance which combines giving and withholding. In subsequent elaboration this would lead to attaching the most positive moral feeling to effort without success. Of course there are undoubtedly many factors from later experience as well which contribute to such an attitude.⁵

To turn to another, not unrelated, item of moral ideology, there may be various beliefs as to the probable outcome of careers which have started off in a good or bad direction. There are numerous and widely diffused sayings to the effect that the initial direction determines or is prognostic for the whole life course (As the twig is bent, etc.). One class of these sayings has to do with the influence of the parents (e.g., 'The fruit does not fall far from the tree'). In contrast to these beliefs, the views of our Czech informants tended to be that one can make no such predictions. When asked what a bad child would grow up to be like if not corrected, they answered 'You can never tell'. If we asked what effect does a good mother have on her children, the answer was apt to be 'I often wonder'. This would be followed by reflections about women who seemed to be very bad mothers, but whose children turned out well. The children of these Czech families expressed similar uncertainty. A girl of nine replies to the question what makes some children good and others bad, by saying 'You can't tell. Once I got such a lot of presents for my birthday and then I was very bad. I really don't know. Sometimes it looks as if being left alone and getting no presents makes children good. I have a girl friend - she is really a good girl and she is left so much alone and never gets presents for her birthday. But I don't know.'

This belief about the uncertain determination and development of goodness and badness, which probably has a very complex derivation, may be in part related to some of the tendencies which we have already observed in our Czech informants. The tendency towards alternate giving and withholding is perhaps expressed in the moral evaluation of others. As soon as one calls a person bad, one then veers to the other side - he may still turn out all right. And conversely if one calls someone good - who knows whether in the end this goodness will amount to any thing? The tendency to oscillate between positive and negative feelings

5 In this connection Czech informants have brought up their image of Austrian rule - a Czech who was successful might have been supposed to owe this more to having ingratiated himself with Austrian officials than to hard work. There were also tendencies towards noncompliance with the officials (cf. the image of the good soldier Schweik) which consisted in giving the greatest demonstrations of zeal while producing none of the required results. Whether these were mainly adult realities confirming early experience or fantasies deriving from it they are congruent with the syndrome which we have described.

is illustrated in a series of associations which proceed by opposites. Sequences in the moral world may thus seem devoid of meaningful connection, the bad may be unpredictably superseded by the good, and vice versa. If we consider a contrasting picture of the moral world in which sequences are meaningful, we might imagine in a simplified way some such emotional process as the following underlying it. When any thing turns out badly for oneself, or someone else, one thinks spontaneously of previous mistakes or sinful acts, forgetting for the moment any thing good or creditable. The present event seems congruous with a long past history, an univocal mood and set of associations is then expressed as a belief in a causal inevitability. The process of association in our Czech subjects is different from this. If a child seems to be turning out badly, one tends to think of all the evidence for the mother's having been a good mother. One sector of the ambivalence does not become exclusively absorbing, but very quickly evokes the opposite sector. This emotional sequence is then expressed in a judgment about the sequence of events in the moral world.

The tendency to react by opposites which we have noted in our Czech subjects may have an interpersonal as well as an intrapersonal application. As illustrated in the mother-child relation, the child may tend to behave in a way opposite to rather than congruous with the mother's behavior towards him. One mother remarks, for instance, when we ask what makes a child good: 'I really don't know. Sometimes you wonder. Sometimes I slap Mary and she will be as good as gold, and sometimes I am nice and good and she's unbearable.' The same mother also remarks on her little girl's reaction to punishment: 'When I put Mary in the corner and then say she can come out, she says "Thank you, now I like it here".' We have already cited the other little girl who recalled how badly she behaved on her birthday. In remarking on the supposed withholding tendencies of these mothers, we have made the guess that their children may tend to react by wanting to disappoint the mother in turn. This impulse may take the form of reacting in the opposite way from that which the mother expects. The child thus demonstrates that he can not be controlled, just as he felt that his mother could not be controlled by his wishes. This feeling of uncontrollability may then contribute to the reactions. I wonder what effect a good mother has, you can't tell what makes a child good or bad.

The tendency to mingle reward and punishment may also contribute to this uncertainty as to the outcome of moral careers. In so far as the child sees a wished-for reward alternately offered and withdrawn, he remains in doubt as to whether he will turn out to have been good or bad. Since children seem susceptible to measuring their goodness or badness in

terms of the deprivations or indulgences they receive, parental indecision in the latter respect would be conducive to the child's being uncertain as to his moral status. The parents' tendency to mingle blame with praise would reinforce this uncertainty. When we asked how a bad child might turn out well in later life, a frequent answer was: he could be changed by love; a good woman can have a great influence. This would seem to express a fantasy of finding a more rewarding mother figure who could relieve the man's uncertainties about his goodness and also provoke less contrary reactions.⁶

Despite the doubts which our Czech subjects expressed as to whether good treatment makes a child good, etc., they were not inclined to generalize from the contrary instances either. They did not cite any such maxims as the old American, "Spare the rod and spoil the child." We have the impression here of an endless oscillation of ambivalence so that the image of a well-behaved but badly treated child also evokes contrary images, namely, of children who turned out badly because of neglect or of good children of good mothers.

A different pattern of reaction by opposites seems to be illustrated by our Syrian subjects. While interpersonal relations may be characterized by contrary reactions, these are taken as sufficiently reliable to make prediction and control feasible. Thus in some cases children may learn: if you ask the parents for anything they will refuse it; if you do not ask, they will give it. One informant gives an illustrative recollection from her childhood. Every evening after supper her mother used to buy ice cream for her and her brother. One evening on the walk to the store, the children were talking of the anticipated treat and the mother overheard them. That evening they got no ice cream. "When we were alone my brother and I talked about it, and we decided that the reason was that mother had heard us talking about it and she wanted to teach us a lesson not to ask for anything . . . I have never forgotten it and ever since then my brother and I never asked for anything. I am going to do that with my baby too." The justification for this contrary behavior as understood by this informant is that "To give a child everything he asks for will spoil him." A less conscious motivation would seem to be that of the parents maintaining an active position while holding the child in a passive one. If the parent gives when asked, he becomes subject to the control of the asking child. We may recall the position of mother and child in nursing as described by some of our Syrian informants: the child remains bound in the cradle while the mother bends over it and thrusts her nipple into its mouth. Subsequent withholding by the mother in

6. Another factor which may contribute to uncertainty as to whether one will turn out to be good or bad is disagreement among adult authorities.

response to the child's active asking would then aim at a re-enactment of the earlier situation in which the mother was exclusively active.⁷ This would not seem to express the same sort of conflict over giving which we ascribed to our Czech mothers and does not lead to the same endless alternation of giving and withholding.

Let us briefly summarize the main hypothetical connections which we have sketched between certain premoral mother-child relations and certain forms of moral behavior and beliefs. Starting with a conflict in the mother about giving and withholding of food we have seen giving and withholding tendencies repeated in reward and punishment. We were led to suppose that the mother's combined giving and withholding tendencies in relation to food were taken over by the child in toilet training where he could disappoint the mother in his turn by giving a demonstration of effort and still withholding his feces. This seemed to be related to the adult moral position which awarded the highest valuation to the person who tried the hardest without achieving success. Uncertainty as to moral causation (e.g., what makes a child good or bad, what is the effect of good or bad parents, etc.) appeared to be related to a number of factors: alternate giving and withholding in the moral estimation of others; uncertainty as to one's own moral score in connection with the parents' tendency to alternate or combine reward and punishment; the tendency of children to behave in a contrary fashion; and the fantasy of a purely rewarding mother in relation to whom one could become entirely good. Thus a variety of moral beliefs and behaviors seemed to be mutually interconnected and to have common ties with certain mother-child relations.

Let us now proceed to consider further variants of premoral experience and the moral attitudes which appear to be associated with them. We spoke previously of the very early inception of toilet training reported by our Chinese informants. The mother is said to pick up the infant from as early as one month on; she does not expect him to call or come to her, or to cede to her direction a function of which he has gained control since none of these things applies to an infant of this age.⁸ She

7 What seems to be a high degree of outspokenness about ambivalence in our Syrian subjects may be related to the method of nursing which we have described. A possible connection between pronounced ambivalence and an experience in nursing where the child feels that he is being aggressively penetrated by the mother's breast has been suggested by Edmund Bergler.⁽²⁾ While Dr. Bergler was inclined to doubt whether actual differences in maternal handling contributed to these oral fantasies, our Syrian material suggests that they are relevant.

8 Related to this method of toilet training there seems to be a relatively slight value placed on punctuality. When we asked our Chinese children what they would do if they were on their way to school and saw they were in danger of being late, they were little inclined to stress hurrying.

assumes the responsibility of discovering the proper time, of learning to interpret the involuntary sounds and movements of the infant. In so far as she stimulates him, it is by little sympathetic sounds, of hissing or grunting, which simulate the sounds of urination and defecation. One apparent derivative of this early toilet training for which the mother assumes the responsibility appears in the following custom which our subjects report. Instead of asking the children at a later age to make good resolutions at New Years, the parents come to the bedside of the sleeping children at night and wipe their lips with toilet paper; this is supposed to wipe away the effects of all the bad things they have said in the year which has passed. Another related point may be the connotation of certain words for naughtiness which emphasize receptors rather than effectors. One such term is literally translated as "obstinate skin"; a term for obstinate is "dead eye of the heart." The image here seems to be nonreceptivity to stimuli rather than tensed muscles and active resistance (contrast our "stubborn as a mule"). This seems congruous with the method of training in which the mother asks the child to respond to sensory stimuli coming from her rather than calling on him for more active, voluntary co-operation.

The participation of the mother in the infant's excretory processes from such an early age may help to perpetuate the child's feeling that his body is connected with his mother's. He may be particularly encouraged to feel that the contents of his body are continuous with those of his mother's body. That the food he receives comes from inside the mother's body may seem confirmed not only from nursing but by the fact that mothers frequently chew the first solid food which they give and transfer it from their own mouth to the child's. The mother maintains her interest in these products of hers after they have entered the child's body and may be felt as presiding over their journey through the alimentary tract, since she is almost always there to receive them back when they are excreted. The feeling of the identity of the mother's and child's body products is suggested in a folk belief reported by some of our informants. Mother's milk is supposed to have a restorative value for adults suffering from certain debilitating illnesses; the urine of a breast-fed boy baby is supposed to be equally efficacious. Related to such beliefs there seems to be a tendency not to devalue excretory products very much; the journey through the alimentary tract does not wholly divest the good food of its virtues. Where the child feels for the moment on bad terms with the mother, he may feel that in charming his excreta out of him she is weakening him. Such a fantasy seems to be displaced to dangerously amorous women in later life, who are said to drain the man of the milk of his virility. In a story which expresses this fantasy ("The Mandarin-Duck Girdle," in: *Four Cautionary Tales*, translated by Harold Acton

and Lee Yi Hsieh London 1947) the unhappy hero becomes the lover of several insatiable young nuns who so exhaust him with their amorous demands that he wastes away and finally dies (Contrast the story in Boccaccio where the hero succeeds in surviving a similar danger)

The feeling of continuity between the inside of the mother's body and that of the child's seems to be expressed in beliefs of mutual influence. Just as the mother controls the contents of the child's body the child is accused when he is bad of causing destructive effects inside the mother's body. Thus a reproach which according to our informants mothers are apt to make against bad children is 'you fill me with gas'. This gas is supposed to be generated inside the mother and to produce stifling sensations in response to the child's badness. The mother may say 'you kill me with gas'—thus presenting to the child the fulfillment of his bad wishes via the medium of his control of her insides. One derivative of this belief is the stress which some of the children of our Chinese parents placed on the danger of leaving the gas on in the kitchen. A ten-year-old boy when asked to write a story about a bad child titled his story "The Frightened Boy" and related: His name was Tommy Lee. One day he did something very bad. He opened the gas by mistake and can't close it. So the gas went under the door and everybody in the house got infected by the gas. Later when his parents came home they found everyone on the ground. They called the police and told them the story. After that he tried to be good and most of the time he was. In a similar way a nine-year-old girl mentions that it would be a specially meritorious act which she would want everyone to know about if she found the gas accidentally turned on and turned it off. This suggests that the choice of physical hazards most warned against in various instances of child training is related to other fantasied dangers which are thus in directly represented.

The feeling of continuity between the child's body and the mother's which is encouraged in the early handling of the infant seems to fit in with a major Chinese moral requirement that the child should perpetuate his family. His body belongs to his family and is the instrument of its perpetuity. If he injures or endangers his body he is punished for having thus damaged or exposed his parents' property. The image of several bodies combining to form a single body is expressed and reinforced in several Chinese children's games described by our informants. In these games a number of children form a composite body and the point is to keep this composite intact. Thus in the Walking Pagodas the boys of each team form a pyramid by climbing on each other's shoulders; the two pagodas attack each other and that side wins whose members maintain their positions in the composite figure without being dislodged.

The continuity of mother's and child's bodies emphasized in infancy

may be utilized in the later requirement that the child continue the family line. The greatest filial impiety is for a son not to have an offspring. The preoedipal relation to the mother may provide a base for the later relation to the father. Just as the infant is led to feel that he receives the products of his mother's body and that she maintains her interest and property rights in these valuable products as they pass through his body, so the son may later fantasy that he receives and transmits generative substances from his father. The docility and submission of the son to the father might be based on passive oral fantasies combined with the feeling that the son's genital activity is directed by the father on the model of body-as-transmitter derived from the relation with the mother.⁹ Obviously there are in general many different ways in which the son's oedipal opposition to the father may be mitigated and resolved. In the case which we have been considering it would seem that the early infantile feeling of the child's body as recipient and conveyer of the valuable products of the mother's body may contribute to the reconciliation in the oedipal phase of the son's genital activity with that of the father. The father replaces the mother as the source of the valuable body products which the son is asked to receive and to transmit.

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9 The intellectual counterpart to this transmission is expressed in the traditionalism of Confucius, quoting Mo Tzu. "I have transmitted what was taught me without making up anything of my own" (4, p. 122) The apparently very gradual development of moral autonomy may also be related to the feeling of continuity with the parents. The individual remains up to an advanced age accessible to moral guidance of parents and other critics with relatively little opposition of his judgment to theirs. Tendencies to resentment, self justification, or counterattack in response to criticism seem to be little in evidence.

DELINQUENCY AND MORALITY

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Many juvenile delinquents have a high standard of morality despite popular opinion to the contrary. August Aichhorn was the first to formulate the dynamic aspects of the delinquent's motivation and to apply such understanding to psychotherapeutic action. He showed how rebellion against standards set up for the child by those in authority may lead to delinquent behavior when adults do not live up to their own demands⁽¹⁾. Viewed in the context of their life experiences, the behavior of many delinquents seems grounded on stricter standards of morality than those of some of their conforming contemporaries. The latter find it simpler either to violate their own inner convictions or to accept a double standard of morality—behaving one way with their contemporaries and denouncing both behavior and friends when called to account by adults.

Other delinquents behave in conformity with the mores of the sub-marginal communities in which they grow up. In such instances delinquency is an economic and societal rather than a psychological problem and remains outside the scope of this discussion.

Fritz Redl has demonstrated that delinquents frequently show a high degree of conformity to the social order of their group. They will cover up for the gang and accept severe punishment rather than betray their own group⁽²⁾. The motivation of delinquent behavior by this type of morality has since been recognized. Nevertheless it too must be differentiated from the problem under discussion which is primarily concerned with some intrapsychic aspects of delinquency and morality.

Concepts of delinquency and of morality—and their interplay—are influenced by the attitude of society toward nonconformists. Society can not sanction independent ethical mores and takes issue with overt actions which conflict with established mores. Because of the importance with which society invests its moral standards, those standards become the criteria for all behavior. When deviations arise, society safeguards its traditional code by immediately questioning the offender's capacity for moral discrimination. By the same token, it must place as much blame as possible on the delinquent. Although the role of parental attitudes in producing delinquent behavior is now widely recognized, there is no such

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readiness to accept the delinquent's subjective morality as a motivating force. The very existence of any subjectively valid standards of behavior is denied because it constitutes a threat to conformity. For defensive purposes and because many adults need to repress their intense emotional investment in a child's delinquent actions, they tend to ignore the existence of a coherent, even if deviate, moral code which may be motivating the delinquent.

In certain situations we have been able to observe that delinquency resulted from the child's exposure to discrepant moral standards, particularly where the child's standards of morality were actually higher than those of his parents. In such cases it seemed to be a strong but ambivalent identification which forced children to adopt standards of greater ethical rigidity than those which governed their parents. Delinquency seems to have resulted when they had to compromise their own moral standards in order to maintain contact through identification.

The recent trend toward a disintegration of traditional morality has transformed such attitudes as "anything goes that's within the law" into acceptable standards of adult behavior. Immediate material gain thus becomes a frequent gauge of success when values are no longer derived from an established system of morals such as religion, or from the internalized content of a superego developed through identification with consistently moral persons.

Under such a code, adults are acceptable to society as long as their actions remain within the limits of the law, even if they seem lawful only by virtue of specious reasoning. But this is not the morality which parents explicitly present to the child. While their own actions are motivated by "what will get by" (which the child observes), they demand that he himself be guided by "what is right." Later this requirement is officially endorsed by school and church, and unofficially supported by reading matter, the radio and the movies. The child who tries to internalize these discrepant demands is confronted by a seemingly insoluble conflict. As he realizes that parents do not live by their own moral teachings, he is faced with two contradictory desires. On the one hand, he really wants to identify with his parents; on the other, he must have the security of social conformity. In many such cases, delinquent action represents the child's attempt to stress his loyalty to a parent of whose actions he is intensely critical.

This conflict between parental action and moral demand is most acutely experienced by children who are also exposed to discrepancies between the moral standards of two parents. Delinquency not infrequently develops within the following family constellation: The mother sets up the more rigid moral demands and fulfills them in practice. Usually she is the

more powerful figure in the home—more restrictive and demanding than the father. But while she provides consistency, orderliness and dependable physical comfort, she gives less immediate emotional gratification than the father.² Thus the father's striving for superiority is constantly challenged. His relentless drive for economic achievement at all cost often indicates a need for some tangible proof of his competence.

Father and child share an equal fear of the mother's disapproval. As companions they achieve instinctual gratification in romping around roughing it on camping trips and indulging in commonly shared infantile behavior. But they feel uneasy because they know that wife and mother disapprove of their actions. While the mother's higher morality is unquestioningly accepted, her disapproval is feared and her protests are resented and experienced as nagging. Such a family constellation degrades the father to the role of an older brother, which adds to the child's confusion. Later, identification with the more indulgent father provides relief since it mitigates to some extent the already internalized strictness of the mother. This then is the family setting which is apt to produce those deviant personality structures in children which may later find expression in delinquency.

Such delinquency often expresses not only the conflict between moral example and moral requests but also an earlier internalized conflict between parental attitudes. In that conflict morality represents an earlier identification with a powerful mother, while delinquency stands for defiance of the mother by a siding with the weak father. These conflicting tendencies lead the child to strive for ascendancy over the father who takes on the role of a sibling. The child acquires a delusional belief in his superiority when his actions become a source of gratification for his father's repressed wishes.

The delusional elements in the moral code of a twelve year-old boy resulted from his conflicting relationships to significant members of his immediate family. His lifelong emotional difficulties culminated in acting out in the form of school difficulties, stealing and arson. The father was sufficiently concerned about his son's delinquency to insist on residential psychotherapy over his wife's objections.

On admission the boy's resemblance to his father in physique, features, motility, gesticulation and the many mannerisms he affected was very striking. But while the father's appearance was distinctly juvenile, the boy's expression—as well as a marked style and neatness of grooming—seemed old beyond his age. His behavior combined an anxious and provocatively exaggerated compliance. His long ing for status was compulsive but it was some time before he was able to estab-

2 If the mother is indulgent and the father's morality very rigid then, in the normal course of events, the child succeeds in integrating parental attitudes. Only very rarely will such a constellation lead to delinquency in an effort to hurt the father where it counts most.

lish himself by earned prestige. His behavior had no inner consistency and he wavered between following timidly after older and stronger boys and bullying younger children by bragging about his father's wealth and prestige.

When the boy was born, the family group was already neurotically consolidated in line with the unresolved needs of the parents. The emotional rigidity with which so precarious a balance is maintained makes adequate adjustment to a new family member quite difficult. The maternal care the boy received in infancy gave him only a minimum of warmth. The older brother remained the mother's favorite. The father's unconscious need to cling to his position as the youngest son in his own family had previously fostered the mother's wish to see her first born as a substitute husband. The father, for his part, had accepted this reversal of roles between himself and the older son. To safeguard his pride he compensated for the challenge to regression by spectacular business successes "at any price."

The birth of the second son (our example) threatened this equilibrium. The father's need to defend himself against primitive competition with the newborn increased his angry claims on his wife and led to the appearance of gastrointestinal symptoms in his neurosis. His dependent needs as well as his attempts to assert himself by various forms of acting out were thwarted by his wife who thus established control over her husband. Her lack of maternal response toward her infant was influenced by her resentment toward her husband and feelings of guilt over her attachment to her elder son. The baby reacted to his mother's coldness with feeding disturbances and hostile clinging. In due course a new equilibrium was established in which the neurotic needs of all concerned were again accounted for. By virtue of his actual superiority over the boy the older son became more securely established as a father figure, while the father himself accepted the role of an older sibling. Father and younger son became closely allied in a sibling relationship in which the father vented his resentment against his wife and against his older son by condoning and even provoking the younger boy's rebellion against his older brother.

In equally vicarious fashion, the father consolidated his dependent claims by exaggerated pseudomaterial concern for the physical well being of his younger son. In this atmosphere the boy developed into a pestering, clinging infantile youngster. Deprived of real status in the family group he was forced to rely on his nuisance value—especially with his older brother whose paternalism was mere role taking.

This balance, precarious as it was, became seriously disturbed when the birth of a third son coincided with the older brother's departure for the army. These changes the boy was unable to master. Hostility released by the birth of the baby was no longer checked by the controlling authority of the older brother against the father's provocation. Thus, desertion by the older brother contributed to the disruption of the boy's tenuous contact with his mother. Among his attempts to recapture security, was the tendency to overidentify with the mother as the strongest member of the family. But while she turned her criticism against the father, he directed his borrowed attitude primarily against the older brother, magnifying petty incidents of the latter's military career into veritable crime and

displacing onto him all the mother's accusations against the father. In such attempts to restore the father to his legitimate role in the family he did what he could to undo the topsy turvy hierarchy.

He subjected his father to repeated tests in the hope of reassuring himself of his parent's reliability. In the course of such testing he managed to involve his father in a minor theft. He confessed this theft to his father in the hope that the latter's unequivocal disapproval would protect him from his own delinquent tendencies. When instead the father suggested (and took an active part in) the secret restoration of the stolen article the boy's security collapsed. Where he had expected protection through the father's morality he found instead an indulgence of aggression toward the outside world. He was forced to fall back on his mother's overrigid morality and to punish himself accordingly but he continued nevertheless to test his father's strength. A sequence of self-inflicted injuries and delinquent acts of increasing severity led to his placement in the therapeutic institution. While his initial but intermittent delinquencies were prompted by his identification with the father, the final delinquent outbreak resulted from his dual effort to establish the father's morality and to secure punishment for his own misdeeds. A state of panic persisted for as long as these tendencies remained incompatible.

The boy was simultaneously criminal, judge and executioner. In this way he internalized the images of significant figures and established delusional control over them at a moment when any actual relationship with them had become untenable. As criminal he expressed his own unintegrated instinctual tendencies supported by deviate tendencies belonging to his father and his brother. As judge he established his superiority over father and brother and identified with the mother—and as executioner he released his hostility against the three images now internalized and fused.

In the course of psychotherapy resolution of the old character structure and the concomitant integration of new concepts proceeded slowly. Rehabilitation was possible only because the personal representatives of the therapeutic milieu stood up under testing. His relationship to them also furnished consistent values with which he was able to function among his contemporaries and to reorient himself in relation to his family.

During the initial phase of psychotherapy he flaunted the grandiose character of his guilt by the way he assumed blame for all accidents and illnesses which befell his various female relatives. His need for being controlled was also expressed in his conviction that the male director of the institution possessed a mind-reading machine. From the outset he immediately played male against female by investing all powers of control in the director and attempting to intimidate his female therapist by examples of his destructiveness to women. It was only much later that he furnished some clues to interpreting this behavior by admitting that he had always felt his mother had powers of divination in regard to his father and himself. While he made use of the psychotherapeutic situation to express his wish to reverse the family situation, he also made efforts to establish himself by means of the behavior pattern which was characteristic of his first adjustment. There again he managed to involve his father. He succeeded in

defying School rules with the help of the father, who indulgently sent him money through the mail. He also used the School as a device for controlling his parents. He provoked the latter to statements which were opposed to staff attitudes and then pinned School and parents down, using contradiction as a means to control them both. Such defiance brought a guilty expectation of reprisal from both School and family, and the result was a constant state of fearful tension.

His concern about moral issues made an early appearance. He was very intuitive about detecting delinquent actions (or even intentions) in others. Whenever he observed misdemeanors in one of the children he would begin to attack figures who were *in loco parentis* with compulsive nagging. In this reaction to the delinquency of others he re-enacted the distribution of morality and delinquency experienced at home by assuming the attitude of his mother against his father. He became very critical of the School authorities and insisted that the culprits should have been punished severely. This plea for a rigid external environment expressed his wish to maintain conflictless attachment to his father by externalizing maternal control. He felt a military academy would be a better place for him because the strictly regulated activities of such an environment would leave no room for temptation and the threat of disintegration.

During this initial period of testing he engaged in his single major act of delinquency at the institution, in the partial hope that his crime would lead to placement in a rigidly controlled environment where he could find security without pressure from inner conflicts. He broke into an office and stole more than a hundred dollars' worth of stamps, most of which he disposed of by burying them in the back yard. He bragged about his delinquent act in an effort to gain status with the other children, but he also flaunted some of the stamps before the counselors so that he would be recognized as the thief. When taken to task he produced the carefully hidden balance of his loot.

To his amazement the incident was dropped after the stamps had been openly restored. He had expected that his delinquency would lead to great excitement among the School population and had hoped to establish control over the School authorities by forcing them to punitive action. He had also expected strict punishment from the director which he then could use in playing the director against his therapist. He fantasied how he would first arouse her pity—casting her in the role his indulgent father used to take when his mother punished him at home—and then corrupt her by claiming that in his estimation the punishment was still inadequate. He had also hoped that his crime might sufficiently embarrass the director to cover up for him as his father had so often done. This incident was purposeful in terms of his efforts at testing the new environment and of the new set of interpersonal relations it offered. It was also an attempt to establish himself within two meaningful relationships—those to therapist and director—by reproducing experiences belonging to his most gratifying human contact of the past, his attachment to his father.

This delinquent episode was not worked through until much later and then was done (mainly) in two steps separated by an interval of months. At that time the disappointment he experienced in his parents on the occasion of a home visit led to new delinquent outbreaks and in two separate actions he expressed

his rage against the representatives of both parents at the School. First he brow beat another child into giving him his whole stamp collection and then without stealing anything he broke into his teacher's room (Parenthetically it should be noted that he took up stamp collecting at the director's suggestion, an activity about which he spontaneously remarked, 'I like it. It keeps me out of trouble'.) Thus in his first act he was dealing with the director as a father substitute by destroying former sublimations. By his second action, which was directed against a mother figure, he negated his former acceptance of School standards and the true prestige he had acquired by academic progress. The latter action he explained by saying, 'I wanted to see if I could still do it.' Both actions indicated that he was able by then to deal with parent representatives separately and distinctly. Nevertheless, since experiences at home had again threatened his security, such differentiated action still had to take a delinquent form.

Initially he had requested strict policing by the director. But such external controls would have precluded the establishment of any true interpersonal relationship to a father figure. External controls were therefore held at a minimum, though the boy distorted many incidents in line with his needs. The internalization of real conscience reactions was possible only as he began to recognize human qualities in the significant figures of the institution. He learned to tolerate permissiveness and to distinguish it from his father's indulgence—which had been ineffectual as well as tempting and therefore a threat to the boy's security. He was amazed to discover that the institution had no objection to his receiving gifts from his parents. It began to dawn on him that it was he himself who felt undeserving of the gifts, because he mistrusted both his parents. Previously he had felt that his mother always gave more readily to his siblings and had always doubted his father's ability to consistently offer the security and affection which the gifts were supposed to represent.

Until conscience reactions were firmly internalized, this confusion owing to mixed moral standards at home was continued at the School. His need to be moral at all times forced him to apply all disciplinary measures to himself. At times he had to identify with all judges; at others he became confused by identifying with all offenders. On one occasion two children who had started to set a fire faced the prospect of having to leave the School if they continued their activities. Although this threat was directed only at the two children involved, the boy interpreted it to include himself. Even when his error was pointed out to him, he continued to feel threatened by the possible repercussions which the delinquency of others might have for him. He had not yet been able to differentiate these children from his father (who had similarly tempted his destructive tendencies), nor did he feel strong enough to withstand either temptation.

The coming of Halloween revived his fears. During his hesitant but elaborate preparations he spoke of the dangers of temptation. He claimed he hated Halloween because the pranks might spell trouble for him. On the other hand, he found it irresistible, since delinquency was still his chief claim to status with the older boys. This conflict brought to light his confusion about size, prestige and status. At home the next oldest member of his family (his older brother) was tall; the one still older (his father) was shorter. If he wished to grow tall and resemble

his brother, he could never be like his father. He had once felt that order could be restored only if shorter men could take advantage of taller ones. Therefore shorter ones had to be clever and cunning. He admitted that a fear of chaos, through lack of control, was one of the reasons he had invested the director with the ability to read people's minds. When he had first realized that the director was shorter than some of the staff members he compulsively watched all men on the street, comparing their size with the intelligence of their facial expressions. He expressed his ambivalence by stressing how confused he was to observe that while some tall men actually did have stupid faces, not all short people looked intelligent. He admitted that he only thought of his father as being clever when he heard how the latter took advantage of people and situations. But he had often doubted his father's intelligence, particularly in the face of his mother's open criticism. Elaborating on the relationship, he ambiguously magnified the father's tendency to "put things over" on others, accepting the father's morals to the extent of his need to admire him. But he immediately switched to the mother's moral standards, when it was a question of his need for ambivalent assertion toward the father and closeness to the mother.

A home visit at Christmas gave him an opportunity to observe differences between the attitudes of his parents with relative objectivity. In his presence the parents discussed the possibility of withdrawing him from the institution and enrolling him at another school. His fears were immediately aroused. First he sought reassurance by falling back on a physical dependence toward the father, but this he no longer found acceptable. Then he coaxed his parents into giving their opinions as to the kind of school they would probably select. The mother was in favor of a strict military school while the father distinctly favored a more permissive institution. He faced their discrepant positions openly and suddenly realized that while neither he nor his father got along as well with the mother as his brother did, still he and his mother agreed on some issues, such as preferring a strict school.

He sensed that his mother praised his behavior during the visit because he had sided with her on the school issue, while he knew in fact that his behavior had not been particularly good. He seriously considered the possibility that his mother too had not always been truthful and that she might in some ways be inferior to his father.

The ability to view his parents more objectively introduced new steps in differentiation which showed further progress in rehabilitation. He grew aware of the relative ease with which he adjusted to the classroom situation and contrasted it with the tension he still experienced in situations involving other children in the dormitory or on the playground—or with the psychiatrist in therapeutic sessions. He openly preferred the classroom situation because there he always knew what was expected of him. In the dormitory or at the psychiatric session, he was not always sure. Such a challenge to spontaneity he could meet only by rigidly correct behavior. In working through this problem, the question of differentiating genuine behavior and pseudo perfection was raised. He immediately challenged the permissiveness he felt to be implied in the stress we laid on genuine behavior as opposed to feigned perfection. By way of acting out,

he called the police, and informed them that a murder had been committed at the institution, thus symbolizing his fear of what might happen if he were to relinquish his pseudoperfect behavior. It was also symbolic of his hostile identification with the father for the following reason.

While doing guard duty during the First World War the father had once shot at a passerby without adequate justification. Therefore in fearing a possible murder, he was identifying with his father—in calling the police with the mother.

The ability to deal directly with his relationship to the father came only after the boy had worked through his fear of retaliation by a mother figure. Rage over helpless submission to an overpowering woman was the main tie which had held father and son in such close rapport. For this reason benign and unconditional indulgence by female staff members of the institution were initially unacceptable to the boy. Only continued testing made gratification gradually acceptable to him without driving him into compensatory rebellion. The realization that some women are benign made it possible for all females to seem less threatening and permitted him to recall first his bad experience with his grand mother and in that context the onset of his delinquency.

At this point (which was one and a half years after admission to the School) he began to deal directly with his relationship to his paternal grandmother. He had taken severe physical punishment from her without complaining because he sensed that he could expect no support from his father and felt that exposing his father's weakness would only make him lose out in the latter's affection. His protective attitude toward the father only thinly disguised his disappointment and rage against both father and grandmother. The grandmother's later illness he therefore experienced as a proof of his destructive powers and as justified punishment. He recalled other incidents in which his appeals to his father had met with adequate emotional response but had remained ineffectual because the mother had invariably interfered. He remembered for example that he had been very lonely when he was sent to camp for the first time. During his parents' first visit he had cried and begged to be taken home. But in spite of even his father's tears his stay at camp was prolonged on the mother's insistence.

Recollection of this incident led to the realization that his first minor delinquencies occurred after that very visit. Other incidents he had already mentioned now appeared to him in a new light. He had bragged about how cleverly his father had prevented the union from organizing the plant he owned. Now he described the event differently: it seemed to him that like his mother at home his father had nagged many workers (they didn't have to take it) into leaving so that non union members got the majority. He realized now that he like his father took refuge in nagging when a frightening situation made him feel ineffectual.

Next he scrutinized the father's immediate attitude toward him. Whenever the father had bragged of how easily he could take advantage of partners or superiors who liked him, the boy remembered having been uneasy rather than impressed. He realized now that what he had feared was that he too would have to submit to such practices because he too liked his father and wanted to be liked by him. He remembered that only recently his father had belied all his

usual affectionate indulgence To impress an older paternal uncle he had asked the boy to substantiate his claims of being a strict disciplinarian By admitting³ to many beatings and by lying to establish his father's manliness the boy not only gained ascendancy over him but his father was also greatly depreciated in his eyes.

More and more he became aware of how in spite of their mutual competitive ness he turned to his father for affection—while the need for strength made him look to his mother He realized that with his father's affection he also accepted his father's values Pride then demanded that he stress identification with his father by provocative behavior but this was generally followed by immediate remorse when judging himself by his mother's strict standards

In thus re-evaluating his parents he took a new and significant step Originally he had made ineffectual efforts to fuse contradictory parental attitudes in his own person next he had differentiated them sharply now however, he could see parental personalities in a more realistic perspective—as individual entities with their individual mixture of personal traits He realized that his mother's aspirations toward perfection did not always represent her true feelings The conviction also grew that his father did not always approve of his own tricky behavior although he might sometimes brag about it His earlier and more simplified picture of the parental personalities represented extremes of their attitudes and had been easier to grasp But the discrepant set of values derived from such extreme attitudes did not lend themselves well to integration New insight into his parents' real personalities made this boy's personal world more complicated but as the difference between father's and mother's behavior became less sharp he was better able to integrate their separate values

The total family constellation was not materially altered by the boy's progress in integration His greater independence and more realistic evaluation of the mother with whom he now got along better proved a challenge to the father³ A series of incidents which took place during a visit at his home at about this time revealed how the boy needed to defend himself from the delinquent tendencies to which he was tempted by his father's attitudes In anticipation of the visit he talked about his interest in guns and about how he envied his older brother who had obtained a license for target practice and hunting During the preceding home visit he had been overjoyed at the father's promise to take him shooting and was now puzzled to find himself so fearful He attempted to deny his fear and thought that perhaps his father might forget or be too busy to keep his promise

Initially upon his return he spoke only of his concern for his father's health and safety of the need for protection through insurance and of the rights and obligations of successors in business He then reported that on two occasions he had burnt himself once when he lit a new stoker at his mother's request and again on the same day when he insisted on tasting a hot drink which his brother had served to some college friends Both injuries took place in the afternoon following a morning of target practice with his father which neither father nor son showed any inclination to repeat

³ The father was undergoing psychotherapy during the boy's placement but that did not prevent the occurrence of episodes such as the one described above

Only after he had reported the self-inflicted injuries could he report the shooting incident. When his father began to shoot, the boy had felt envious of his skill. He feared first that his father might use up all the bullets and then grew panicky at the idea that his father might hit him instead of the target. At this point he "inadvertently" released the burglar alarm and enjoyed the father's embarrassment when the police arrived. It was also during target practice that he suddenly recalled a long forgotten story told to him by his brother many years before, and alluded to above: his father while doing guard duty had once injured two men through carelessness.

The wish to outdo father and brother at shooting only partly explains his reaction of panic. Actually he was defending himself from the awareness of his father as a tempter. When he policed his father by sounding the burglar alarm and later when he burnt his fingers he regressively relied on attitudes derived from his relationship to more original figures of authority—his mother and his older brother. He exposed the father as the mother had often done, relinquished any aspiration to being the brother's equal and submitted himself to both.

Because the father had become too dangerous the boy could no longer accept any indulgence from him. In his early childhood recurrent coughing had invariably brought physical attention from his father. He commenced coughing shortly after the shooting incident (and while still at home) though there had been no sign of his former ailment for more than a year. Now it was up to him to tempt his father, and to prove that he was strong enough to resist him. The father promptly responded with solicitude and medication, both of which were dramatically rejected.

For the rest of his stay at home he was quiet, subdued and stayed close to his mother. During that time he took occasion to question his father's women employees about working conditions and later made an unfavorable comparison between his father's practices and the employment situation of the maids at the institution. (The latter he investigated thoroughly upon his return.)

These inquiries ended with the conviction that the double standard of morality observed in his family—one for home consumption and another for business—was not really necessary. He realized that a large institution such as the School could be run successfully on the basis of moral standards which were fully as high as those of his mother and which were nevertheless neither rigid nor ungratifying. The final and most important insight he gained was that for him too life could be gratifying both morally and emotionally.

Disappointment still led to mistrust or to negligible flare-ups of acting out. But he was beginning to consider his future as an adult and to seek images for it in men he could like and respect. He realized that he was still occasionally tempted to commit delinquent acts but felt more adequately protected by his new ego ideal than he had been by the previous fear of his conscience. The latter had only forced him to seek punishment after each contemplated or actual misdeed while his new ego ideal served to prevent him from delinquency in the first place.

In summarizing the case it may be said that it was moral issues rather than emotional experiences which determined this child's evaluation of

his parents in a family situation where parental interaction was characterized by an overt and latent clash of moral concepts. For him and other children in similar family constellations the oedipal situation cannot take the usual form of emotional experience, regulated by secondary conscience reactions. Instead, emotional strivings find devious expression in a constant wavering of moral standards. It becomes too difficult to develop a coherent character structure by internalizing reasonable modifications of parental attitudes, because in contrast to emotional strivings, morality does not lend itself to compromise.

In rehabilitating such children, personal interaction must be provided which (though in line with a consistent morality) is determined and regulated by other than moral categories of experience. In their reactions to the child the significant adults have to provide real gratification and express genuine emotions if moral standards are to be integrated and applied as such. In the above case this form of experience was possible only after prolonged treatment had given the boy repeated opportunities to subject his personal environment to the fine, but variable screen of his own confused morality.

Both the delinquency and rehabilitation of this boy are characteristic for situations in which a child uses the stricter morals of the mother as a defense against temptation from the father.

Ego-acceptable identification with the father is an important factor in the process of personality formation in general. Even when the child's relationship to the father becomes questionable, his relationship to, and identification with, the mother may still fulfill important functions in maintaining his integration. A succession of factors, each of which may have threatened the child's relationship to either parent at particular moments of his life history, may still become integrated in the child's personality structure. However, it is at critical moments in personality development that a combination of factors, which were manageable enough coming singly and in succession, may seriously disrupt integration.

The ways of achieving mastery over instinctual and societal demands are what finally characterize personality formation. During adolescence, it is the ability to conform to the acceptable moral standards acquired during the latency period which makes it possible to maintain personality integration against new instinctual pressures. On the other hand the discrepancy of moral standards between parents makes it difficult for the preadolescent to establish a coherent morality and deprives him of an important tool for mastery and adaptation.

Rigid moral standards as a personality trait are frequently accompanied by a chronic coldness in human relationships. If such an attitude is characteristic of the mother, all relationships of the child are tenuous.

from the start. Minor events threaten the relationship to the mother and force the child into closer contact with the father or other members of the family. But the substitute character of such relationships, as well as the guilt over hostility toward the mother, burden the substitute relationship with retaliatory fears. If, in addition, the cold and rejecting mother is also the more obviously punitive and moral one, any closeness or affection which the child may experience in his contact with the father seems punishable to him.

Contact and identification with the father is further complicated where that parent is too largely connected with a child's memories of affectionate gratification. To preserve the father as a source of gratification, the child is likely to try to live up to his expectations—however devious they may be—and to the limits of his biological capacity. Such exclusiveness is of necessity mutual. The strong investment which both parent and child have in their relationship, accounts for an extreme sensitivity to mutual but not necessarily conscious needs. Every stimulation becomes a temptation, although the roles of tempter and subject vary with the defensive integration of parent or child. Accordingly, many parents can maintain their moral standards only on the strength of their child's delinquency. Their own adjustment is seriously threatened when the child becomes able to defend himself from temptation and no longer relieves his parent of the tension of unfulfilled desires, or of incompletely repressed wishes, by his delinquent or other symptomatic behavior.

Through the child's symptom the parent can indulge an infantile wish with less anxiety, by virtue of age, size and traditional authority, he can now exercise some control over impulses which he has failed to master in himself. But the child's symptom remains of spurious psychoeconomic value to the parent, for control over the child cannot lead the parent to integrate the particular impulse. However, since the child's delinquent behavior does bring the parent actual if only temporary, relief from tension, parental provocation of delinquency in the child becomes constant in many instances. In other cases it occurs intermittently, with the fluctuation of parental needs. Provocation cannot cease unless the parent achieves real integration and can relinquish the child's symptom as an outlet for his own tension. A parent who thus finds recurrent relief from the pressure of his unresolved conflicts becomes addicted, as it were, to the child's symptom, while the child, at the price of security, achieves undue power over his parent.

The symbiotic involvement which results is incompatible with distance. Therefore the parent has to counteract any emancipation on the child's part. In this respect the child entering adolescence becomes a particular challenge since the adolescent's assertive independence is felt as a

threat by the parents, while his greater need for identification is misused by the parent to cement closeness through seduction. Parental exertion, however, is counteracted by the adolescent's rebellion against control as well as his fear of giving in to any form of excessive instinctual demand at this particular phase of development. Such fears lead him to regressive attempts at recapturing his position with his moralistic parent who seems to offer security against instinctual tendencies. In return he may give up all desire for emotional gratification, even those which are legitimate. If he succeeds in reviving identification with the sterner parent, the result is a permanent freezing of the personality. More frequently such efforts yield only temporary relief and finally result in an unintegrated wavering between moralistic and delinquent tendencies. Delinquent acts in that case are often no more than efforts to protect the morality of the indulgent parent, or the tendency to seek punishment even for thoughts or silent wishes. Such behavior may persist not only during adolescence, but throughout the individual's lifetime unless, in his relations with more adequate parent figures, he succeeds in internalizing new moral standards. This, however, can only be achieved through the consistent experience of emotional gratification which does not conflict with his personal security.

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THE MOTHER IN THE CONSULTING ROOM

NOTES ON THE PSYCHOANALYTIC TREATMENT OF TWO YOUNG CHILDREN

By HEDY SCHWARZ (London)

The conditions under which a child begins treatment differ greatly from those under which an adult patient starts. The child never comes on his own decision; he often does not suffer and it is not he but his parents who make sacrifices for his treatment. From this it is clear that the parents' attitude to the child's treatment is a decisive factor in analytic work with children.

Whilst in the treatment of adults we avoid any direct contact with the patient's family, in child analysis we have to discuss all practical questions concerning the treatment itself as well as educational problems arising during treatment with the people responsible for the upbringing of the child(5).

This paper deals with the co-operation between analyst and parents and in particular with the problem of the young child in analysis and the mother's attitude towards the analyst. The prelatency child has always presented the analyst with special problems as is shown in the interesting cases described in the analytic literature(1, 2, 8, 10).

Knowledge of the paramount importance of the early years of life is steadily spreading and most parents watch the development of their children with great care and attention, noticing difficulties much more readily than in former times. Yet there exists a deep reluctance, especially on the mother's part, to send a young child to treatment.

We all know that the narcissistic relationship of the mother to her child changes only very slowly into an object relationship in which the child gradually becomes an independent personality and ceases to be looked upon as part of the mother's own self. The disturbance of latency children is often first observed in school or outside the family circle; it is often the teacher's judgment of the child's behavior in school that influences the parents in their decision about treatment. With young children an enlightened family doctor may be the one to advise analytic help. But the mother will try everything in her power to cope with the young child's problems herself.

This intimate relationship between mother and young child makes advisory work with mothers of prelatency children so successful and preferable to the treatment situation which interferes so radically with the bond between mother and child.

Yet there are cases where advice given to the mother does not suffice. The mother is then torn between her wish to possess her child exclusively and her knowledge that she cannot help him.

From watching a conflict of this sort in the mother of a little girl of three and a half, I got the idea of suggesting to the mother that she should come to the treatment with her child and see for herself what I did, so that she might use the analytic knowledge thus gained in her own handling of the child.

I

Nancy was suffering from a severe feeding inhibition. She had never been a good eater, but at the time of our first meeting, which took place in her own home, four months after the birth of Henry, her baby brother, she seemed to have given up any pleasurable acceptance of food. The child made an appalling impression. Thin, pale, and with a deadly serious face, she sat with us at the tea table where she was offered some orangeade and a biscuit. She did not touch the orangeade at all. The biscuit she lifted repeatedly to her mouth as if she were about to eat it, only to put it down again untouched. This was, as her mother told me, her usual behavior at mealtimes. If the mother consented to feed her, she ate terribly slowly and kept her at the meal for hours. The arrival of the brother had started the deterioration of Nancy's feeding. The mother, with good but misdirected intentions, had invited Nancy to watch her breast feed the baby, and even tried to make her have her own meal while watching. Only when Nancy went on a hunger strike did the mother realize that her idea was not as successful as she had expected and separated the children's mealtimes.

Eating was not the only way in which Nancy tried to exasperate her mother. When they went anywhere, she dawdled and had to be dragged along. In the mornings she would call her mother to dress her, but as soon as the mother came to do it, she refused to be dressed and ran away only to repeat the performance in a few minutes time. The mother was a former teacher, a very active and efficient young woman, who liked "to get on with things." She could hardly bear these constant provocations and there were sometimes violent scenes between mother and daughter. The father was a very quiet, stable person, deeply fond of the little girl, and with a special understanding of her feeding problems as he himself had suffered all his childhood from a similar inhibition. It was his idea that Nancy should have treatment; the mother was vehemently opposed to the idea. Only when Nancy began to stammer a week after my first visit and I could show her that this symptom was connected with the eating disturbance did she become seriously perturbed. Yet she put forward all possible practical difficulties to convince herself that Nancy could not be brought to treatment, until I at last suggested her coming with the child as observer.

I myself did not know how this situation would work out but my wish to help both mother and child gave me the courage to try. Nancy's treatment proved a great success: the little girl had a command of language astonishing for her age and was able to express herself well in words and play. The bulk of the analysis was carried out with the help of two little dolls: a boy and a girl (Peter and Margaret) who represented all her sadomasochistic fantasies which had also so affected her eating (6). Peter would usually refuse the very thing Margaret was begging for; Nancy would then whisper to me: "Make her cry, make her cry louder"—and her face would beam with the satisfaction of being the torturer as well as the victim.

The mother listened spellbound to the material produced in each session and to the interpretations which I gave the child. She never interfered but co-operated tactfully when drawn into the conversation. Nancy repeated in her play behavior the same inhibitions she had shown in her eating. She would stand for a long time with the paint brush in her hand, unable to put it into the paint and crying bitterly when the time was over and she had not done any painting.

From the first session onwards I had on a table some food which I offered in a casual way to mother and child, saying that anybody who felt like eating could always take as much as she liked. While jealousy of and aggression against the little brother were being thoroughly interpreted, Nancy began to attack the baby openly. She had never shown any direct jealousy and the switch-over from her paralyzed passivity to activity and aggressiveness impressed the mother so deeply that she was able to bear Nancy's aggression as a temporary state and did not frighten her anew into submissiveness. (I would like to mention here that for the first few weeks I discussed every single session with the mother afterwards by telephone. Later she understood the material herself and only asked when she was not clear about some detail.) Nancy soon stopped the acting out of her aggressions and began to help with the baby in all sorts of little ways. At the same time she adapted a nursery rhyme to her needs:

Ding dong bell
Henry's in the well

laughing happily over her joke. She also began to be interested in the cake or biscuits in my consulting room. Often immediately after an interpretation of her jealousy she would rush to the plate and gobble up the food, shouting: "There's nothing left for you." cramming it into her mouth. It is not my intention in this paper to give full details of the history of Nancy's treatment as I want to discuss mainly the technical implications created by the presence of the mother in the analysis of the child.

When I had invited the mother to come with Nancy, I had vaguely mentioned the first stage of the treatment wanting only to help the mother to make up her mind about Nancy's having treatment. Only as the treatment went on did I realize the dynamic value of this miniature group formation: how the mother was influenced indirectly by my analytic approach which so patently respected the child's self-expression.

how her patient interest as she watched the child's sessions, so different from her usual haste and bustle, had in itself therapeutic effect on the child, and how I for my part learned to formulate my interpretations more and more clearly so that they could be understood by both mother and child

It is one of the great advantages of mother and child being together in the treatment that in the child's mind there is no clash of loyalty towards analyst and mother and that the child patient does not, as so often happens in child analysis, need to feel guilty for trusting the analyst or confiding his secrets to her. Neither can the child have the impression that there are two sets of standards, one which the mother approves, one which the analyst approves. If we treat a child without the mother being present, we often try to get the mother to change her attitude officially and to tell the child that she does not disapprove of the interpretations the analyst has given. But there is usually a gap between our work with the child and the mother's statement, and it is during that time that the child feels guilty and insecure, so that we often have added a new conflict to his old ones. For the young child the physical presence of the mother during the treatment is a constant and much stronger proof of her tolerance and understanding of the analytic work than any verbal declaration.

When Nancy had been in treatment for two and a half months, the mother and father unexpectedly had to go abroad for four weeks. When alone with me in the sessions, Nancy brought out a lot of material concerning her jealousy regarding the oedipal situation. She begrudged her mother everything she bought for the journey, especially a new coat, since Nancy wanted one for herself. During this period, she also brought up the restrictions which her mother had imposed on her about sex play, which consisted mostly of advice to keep her hands outside the blankets when tucked in bed. That the timing of this material was influenced by Nancy's reaction to the absence of the parents is obvious. But through this external division of Nancy's treatment into two phases, I was not yet able to work out which problems a child of this age can or cannot solve in the presence of the mother.

As to how long the mother should be included in the treatment, I do not feel that I have had enough experience to generalize. What I know from my occasional advisory work with mothers of young children is the fact that at this stage of the child's development the mother can absorb a great deal of analytic knowledge about her child's libidinal as well as the aggressive impulses even though they are directed against her. It might be the primitive nature of these impulses which makes it so much easier for the mother's superego to recognize them in her young child.

The effect of such knowledge passed on by the analyst in an advisory

function depends, above all, on the mother's capacity to form a positive relationship to the adviser. Might it not be that if we accept the mother of a young patient as part of his treatment, and if we can be entirely free of any desire to patronize the mother or to 'make good' what she has done wrong with the child, the wish to have the child alone for treatment as soon as possible might recede, and we would be able to base our decisions about the mother's presence in the treatment, entirely on the needs of the specific case? There are certainly cases where it is not advisable to have the mother in the consulting room for a long period. The older the child—that is, the nearer the latency period—the more the child will need to have his sessions without the mother, but I would always advocate occasional sessions—arranged with the child beforehand—in which certain fears, wishes, ideas and complaints of the child are discussed in the mother's presence.

If it is a symptom of the child that he cannot separate from his mother, as was the case with Bobby whose story comes next, the mother must be told at the beginning of treatment that it will be a sign of great improvement when the child is able to stay with the analyst without her.

Even from the limited experience I have had so far, it seems certain that the mother of a young child is so grateful for being allowed to take part in her child's treatment and so relieved that the child is not taken from her, that she forms to the analyst a very positive relationship which later on weathers many restrictions or frustrations imposed by the child's needs. It is our task to cultivate the team spirit by preparing the mother in time for each new move and explaining to her our analytic reasons for them. But this weaning of the mother can become a source of conflict. It must be timed to meet the mother's needs even if it might mean keeping the child back for some time. Better this than to lose the case altogether.

We must always keep in mind that only with the mother's full co-operation can the analysis of a young child be safeguarded(3)

And now two more points in favor of the mother's presence in the consulting room

First A few of the cases described in the analytic literature(1, 2) have been analyzed not in the consulting room but in the child's home, as the treatment situation in the consulting room was felt to be too unnatural for children who had not yet known any but their familiar surroundings. The power of expressing his conflicts in words or of making himself understood has often not yet been acquired by the young child. In this respect, Nancy was a very exceptional child. Our second case, Bobby, was a very poor speaker who at times used a kind of baby language which the mother had to translate for me. In all cases of young children the analytic procedure is dependent on the information received from the child's en-

vironment I find it more economical and much more vivid if such information is given in the consulting room by the mother in front of the child, so that all three of us are working together as a group

Second The analysis of a young child can never be restricted to the analytic session The child's questions, for instance, will go on after the session We cannot demand from a two- or a three year-old that he save his questions until he comes to the next session or to control his acting out as we try to do with older children in treatment The young child, with his immature ego organization, sometimes changes his symptoms from day to day Whether we permit the mother to take part in the treatment or not, she has to cope with the neurotic child for the remaining twenty three hours of the day If she has been in the session, she will be able to understand the change of the symptoms together with the analyst and she will neither get too optimistic if a symptom disappears nor too depressed when a new symptom develops Nancy, for instance, during the period in which her penis envy was in the foreground, began to do her big job in her knickers When her mother asked her why she had not asked to go to the lavatory, she said to her It makes me feel so nice, mummy, to keep my jobby in. It makes me feel as if I had a tail like Henry

It is the great advantage of treating young children that their ego and superego formation is still flexible and that our analytic efforts can comparatively quickly free the child from anxieties Anna Freud(5) mentions a case of Dr W W Wulff an eighteen month old child whose severe feeding disturbance was quickly removed when the parents were advised to postpone toilet training The younger the child the easier is the freeing of libidinal drives but the freeing of wishes is not our ultimate aim Pre-genital drives cannot be satisfied but must be partly repressed, partly sublimated We did not want Nancy to indulge in anal play educational means must be found to make it possible for the child who feels his sexual demands to forego the pleasures of direct satisfaction for the sake of the beloved person who does not favor direct gratification In the case of older children we often try to influence the educational atmosphere in which the child grows up during and after the analysis and we do as little direct educational work in the analysis as possible The less co-operative the parents are the less willing to change their own educational methods the more we have to undertake ourselves, but very often with the unpleasant feeling that after the analysis is finished the child's dependence on his parents and educators will force him back into the neurotic attitude which we have tried so hard to turn into a more rational and economical one(5) The younger the child the easier it is I think, to make the mother understand her child's conflicts and the ways in

which she can help him to deal with his wishes. Thus we can achieve a perfect synthesis of therapy and education. With Nancy's mother, I discussed in great detail the type of nursery school in which Nancy could find the best opportunity to sublimate her exhibitionistic and anal wishes which formed the acute problems of her development at that time. With certain mothers, however, there is a danger that they may at least temporarily, become too analytic. It is our task to distribute the roles of the team and according to my experience the mother understands very well that her presence in the consulting room does not mean her assuming the part of analyst towards her child.

Nancy's treatment (four sessions per week) lasted for five and a half months during three of which the mother was present. After the end of the analysis she telephoned me or came to see me whenever something special occurred or whenever she wanted to discuss a problem. It was encouraging to see how well she was able to apply her new understanding to the upbringing not only of Nancy but also of the younger child.

II

And now to Bobby aged three and a half a case in which the mother was much more than an observer. Bobby had been taken to a psychoanalyst acting as adviser in a Child Welfare Clinic.

He showed a severe tic¹ consisting at that time of violently wiping his face first with his right hand then with his left jerking his head backwards over his left shoulder and rolling his eyes. The mother had previously been to four children's hospitals where the most divergent opinions were expressed ranging from 'Don't take any notice of it he only puts it on for your sake' to diagnosing Bobby's case as chorea. The colleague who saw the child felt quite rightly that she could not cope with this case by advising the mother because the child's disturbance seemed beyond such a remedy. She also felt that the mother was not a suitable case for advisory treatment because of her own difficulties and she passed the case on to me for proper psychoanalytic treatment.

Mother and child at that time were an inseparable unit and however much I might have wished to see the mother on her own it seemed practically impossible since Bobby refused to be separated from his mother and literally clung to her with all his might. Bobby is the youngest of four children aged respectively eighteen thirteen and eleven. It is a working class family the father being a highly skilled worker. The mother's mother had always lived with them. They are not poor but live in cramped quarters. Not one member of the family has a bed to himself the eldest boy sleeping with the eleven year old the thirteen year-old girl with the grandmother and Bobby having slept in the parents' bed since he refused to sleep in his cot at the age of two.

I call Bobby's symptom a "tic" for the sake of brevity and in the wider sense in which it is used in popular language without attempting to define the exact clinical symptomatology of the case (7-9)

At the first session I asked the mother to sit in a comfortable chair in the play room expecting her to watch my work with Bobby as Nancy's mother had watched me with Nancy. Instead of doing this, the mother began to talk incessantly, telling me the story of Bobby's difficulties. My first impulse was to stop her and to get her to wait until we had an interview without the child. On second thought I decided that it was much better to let her tell her story which after all, the child had certainly heard many times and which gave me an excellent opportunity of seeing the mother's attitude towards the child as well as his reactions to it. The mother first of all poured out her experiences in the various hospitals and with the various doctors how they had not understood Bobby, how desperate she was about him and how grateful that she had at last found someone who listened to her and tried to understand the child. I repeated over and over again that it would take a long time to understand why Bobby did these funny things but that I was sure that there was a reason for them and that bit by bit she and he and I would come to know what he wanted to say by his gestures.

On my suggestion the mother tried to piece together the events precipitating the development of the symptom. She was an excellent observer of the child owing to her deep attachment to him. She mentioned three events that might have acted as traumatic experiences all of them happening shortly before the development of the tic (the tic had begun one month before Bobby was brought to treatment). The most important of these events was that Bobby ran into a swing in the park and was knocked down by a boy on the swing who was wearing a leg iron. Bobby was stunned and very white but not unconscious. The shock is proved by the fact that he did not cry immediately but only when picked up and made a fuss of. The second event, which had happened two weeks previously consisted of Paul the eleven year-old brother bringing home a pet hamster. Before there was any time to warn him Bobby in great delight at the interesting pet put his finger into the cage to stroke him and was bitten. Shortly afterwards the hamster died and, from Bobby's point of view, disappeared. Again the shock effect was the unexpectedness of the attack the blood the incongruous upset of the mother who did not know what to do and had to run to a neighbor to stop the bleeding and finally the disappearance of the pet animal which Bobby might have taken as punishment of the aggressor. The third event mentioned by the mother was Bobby's vomiting for the first time in his life during his sleep and waking up to find himself in a great mess. She also mentioned that he had recently had a bad cold and did not want to have his nose wiped as it was sore.

During these first sessions in which the mother gave me this information Bobby played most of the time with trains which he had brought with him interrupted only by the constant tic actions. He fixed the carriages together and moved the train up and down the long table. He sometimes looked up and listened to the mother's talk. At such moments I always turned to him and made a direct remark to him about what his mother had told me in contrast to my usual listening to the mother and responding to her stories with interpretations about Bobby, such as "That must have frightened Bobby, don't you think, Mrs.

D?', or by saying to her, 'Yes I know a little boy who did exactly the same thing when he was frightened,' or 'That is what all children do when they are three years old, like Bobby,' or 'You see, he wants to do what Paul and Molly, his brother and sister, do'

Besides the tic, the mother complained of Bobby's being very difficult to handle. According to the mother's report he used to do very queer things at home by propping his feet against a chair, he would stand on his head and at bedtime, for instance, had to be forced out of this position against his violent resistance. This had produced a red mark on his forehead which the mother some times suspected of being a remnant of the swing accident (which it certainly was not) and which Bobby began to wipe in his usual tic manner during the sessions indicating thus that the wiping gesture had apparently to do with wiping off pain and discomfort. After two weeks the tic actions varied from day to day in such quick succession that it was impossible for us to follow them with our understanding. There was one day when Bobby wiped his back downwards from left to right, another time when he stroked his legs from the ankles upwards to his knees, another time he would crouch and stroke his legs at still another he would wipe his face and then touch the table top or touch the wall with one hand so that he seemed much more like a case of compulsive touching (doing and undoing) (4) than a tiqueur.

The child's frequent mentioning of the sister in his scanty verbal communications during the sessions led me first to suspect her closer connection with his disturbance. Then the mother reported one day that Bobby had thrown Molly's golliwog down the lavatory and was just caught when trying to pull the chain. He had also tried to tear another of her dolls to pieces. His constant reply to why he had done all this was 'I don't like her, I don't like Molly' and on more persistent questioning 'She breaks my things she has broken my fire engine. There was some truth in this accusation—Molly had really played with his fire engine and the little bell had come off. Bit by bit I learned that Molly was a great acrobat who did all sorts of exercises and tricks at home. She is the only girl among three boys. Bobby's standing on his head was definitely a copy of one of Molly's tricks and it is likely that some of his other repetitive gestures were also imitations of Molly's exercises. There is good reason to assume that Bobby's identification with Molly was based on admiration as well as on fear (identification with the damaged person) and that his fear concentrated around some observations he had made of Molly's body when she was doing her tricks. It was at this time that he noticed the slightest crack in a brick.

When in the treatment in great excitement over his play Bobby began to touch his penis which he called his 'Peter' and the mother tried to stop him I told her of the frequent displacement of masturbation from the penis to other parts of the body as a result of a castration threat and again I spoke to her about it as if speaking to the child. She then volunteered the information that Bobby was often teased by her and the older children and told that his tail would be cut off if he played with it. It is easy to understand that it was just Molly the only girl who indulged with the greatest pleasure in this teasing. Whether she had done more than tease the little boy I do not know.

That Molly felt very guilty about Bobby's illness was expressed in her having an accident which was strikingly similar to an accident Bobby himself had had.² He had run into a tree. Molly, when out in the country with people who usually only invited her brothers, ran with open eyes, so to speak, into a barbed wire fence and nearly "lost her eyes." Whenever possible, I repeated my interpretation of the wiping as a masturbation substitute, telling many stories of little boys who had scratched their heads or picked their noses, and so on. The tic disappeared entirely by the fourth week of treatment and only came back on rare but instructive occasions for instance, when the grandfather visited the little boy and excited him terribly with romping or when the mother had a big scene with Molly and hit her, or at times when the mother and father had a terrific quarrel and the mother threatened to kill the father.

Transitory symptoms now appeared. Bobby began to soil himself and to wet in the daytime. He would not have his hair cut and he refused to be washed, his face especially being taboo. All these things could be explained to the child and the mother together as sexual excitement on the one hand, on the other as fear of the hitting (castrating) mother.

Bobby composed one or two little stories. They all contained oral sadistic threats: he also developed a peculiar stammer and tongue clicking. These are the stories:

(1) A little boy Clany burned his tail, his mouth and his face (Q. How did it happen?) He put pencils into the fire and burned his arms and then he was taken to the hospital by a van. They took all his jerseys off and ate him.

(2) Once upon a time there were seven aeroplanes and they dived down into the sea and then a big bird came and ate all the pilots and that is the end.

The fixation to the oral level can be explained by the fact that Bobby experienced great satisfaction on this level: he was breast fed up to twelve months and very much admired for his first speech-efforts. I learned comparatively late from the mother that a few months before the traumatic events mentioned above, Bobby had passed through a period of intensive biting which she dealt with by smacking his face severely. She said that he mainly tried to bite her and Molly. This biting phase, at the age of three, must already have been a regression to the oral-sadistic level caused by traumatic events and observations, for which there was abundant opportunity in Bobby's environment.

I have put together this information acquired from mother and child to outline the case, but I have not yet given a full picture of the mother's behavior during the treatment. From the beginning, throughout every session she recited her complaints and accusations of her husband, how she hated him, that he did not speak to her, that he did not sleep with her, that she would run away from him and leave them all, that she would take only Bobby with her, that she would kill herself, that she

2. Bobby's ambivalence towards his mother was dramatically expressed in his clinging to and his running away from her into danger.

would kill him, that life was not worth living, that it was only for Bobby's sake that she kept alive

It is clear from this description that the mother was in a disturbed state herself and as much in need of help as was the boy. Her complaints had a real foundation, her husband had turned into a queer person during the War and after being discharged from the Army, against his wish, when Bobby was born. He withdrew from his wife, did not speak to her and indulged in pornographic sadistic literature. That she tried to force him out of all this by shouting at him and making scenes and that she quite openly used Bobby as a substitute for her husband's affection and to make the husband jealous, had its roots in her own immature personality. Knowing that I could neither change the unhappy family conditions, help to settle the conflicts directly, nor take on the mother as a patient, I accepted the mother as part of Bobby's life and neurosis and tried to cope with her problems within the child's treatment and for therapeutic benefit. In this attempt I was influenced by Dorothy T. Burlingham's paper, 'Child Analysis and the Mother' (3) in which the problems facing the child analyst were for the first time comprehensively stated with all their implications. The impressive description of her attempt to keep a five year-old girl in analysis against the unconscious resistance of the mother, due to the mother's own sexual difficulties at the time, has greatly stimulated further work on the crucial role of the mother in a young child's treatment.

The setup facing me in Bobby's case was of an acutely disturbed child and a mother trying to use his analytic sessions to pour out her own problems. I could have silenced the mother during the sessions on the basis of my authority, but it would have meant depriving myself of seeing her real attitude towards the child and giving the child a kind of artificial peace, which would allow him no chance of expressing his aggressive and hostile feelings. My therapeutic efforts were directed

- (1) towards giving the mother relief by letting her release as much tension as possible in talking (catharsis)
- (2) receiving her accusations and complaints with such calmness and equilibrium as would act as a reassurance to Bobby, showing him that I was not upset by his mother, that she could not provoke me into any scenes,
- (3) explaining to the mother, and to Bobby at the same time, that I understood how hard the father's behavior was to bear but that it was not his fault and that she in her turn provoked him more and more

- (4) letting Bobby express in the form of play his longing for a father and mentioning the father's good sides whenever possible,
- (5) and finally, and this point was the most important from the child's point of view, pointing out to the mother the direct effect on Bobby of her excited accusations and her childish wish to fight with her husband all the time

For Bobby began to get highly excited after her outpourings, throwing things about wildly and climbing onto the top of the table, gesticulating and shouting. These dramatic changes in the child's behavior, from playing peacefully with his trains to wild agitation—always accompanied by the tic movement as long as he still suffered from this, and later by touching his penis—slowly convinced the mother that her devotion to the child did not make up for the harm she did to him unwittingly as a revenge on her husband. She herself later observed and reported the recurrence of the tic after scenes at home.

In the same way, that is, in the child's presence, did I learn of the most dramatic of the traumatic events that had occurred to Bobby and which the mother had hitherto kept from me: she had been pregnant and had had a miscarriage while alone at home with Bobby. For this she again blamed her husband exclusively. He had not helped her to hang the curtains so she had had to get up on the steps and had fallen down. The throwing of Molly's golliwog into the lavatory and many of Bobby's games now received a deeper significance, and most of all his constant playing at being a baby, of which wetting and soiling were one part.

My therapeutic aim as far as the mother was concerned, centered in the hope of her ultimately identifying herself with me in my efforts to understand the child. And I felt very pleased when instead of complaining monotonously she began to put together her husband's childhood history and to link up his present difficult behavior in the light of his terrible anger with his own mother who, after he had been the youngest and the only boy up to the age of thirteen, gave birth to a baby brother, concentrating all her love on this latecomer, and neglecting the older boy whom she had spoiled so long as the baby of the family. I encouraged and praised Mrs. D. for these attempts at understanding her husband as well as for her good and detailed observations of Bobby.

At this time in the sessions Bobby began to show definite signs of independence of the mother and a positive transference towards me. More and more often he invited me to play with him under the table. As I did not want to make the mother too jealous and so disturb my good relationship with her, I began only very slowly and for short periods at a time to take Bobby with me to the kitchen to make tea or have a drink.

At the same time I accepted the mother's offers to help me' by posting a letter, washing teacups and so on. She understood my wish to be alone with the child and was now able to accept this frustration on the basis of her strong positive attachment to me.

Bobby has so far never missed a session, but since I have had him on his own the mother writes me a letter nearly every day (containing her usual complaints and grievances) as a compensation for her self-discipline in letting the child part from her. I see the mother sometimes for an evening session. I also get a useful report from her at the beginning of each session and in Bobby's presence, which often serves as an introduction to his session. Only since being alone with me has Bobby begun to show the whole range of his conflicts and his harassing uncertainty as to whom to take on as his ego ideal. He sometimes screams and shouts in great excitement, hitting my table. 'I will kill you, I will kill you, I wish you were dead,' words which his mother has used to his father, or he will meet all my questions and attempts at conversation with the same provocative silence with which his father frustrates his mother and drives her into angry outbursts.

Although the child is at present free of symptoms, I think that he is still endangered by the emotional upheavals in the family which make it so difficult for him to desexualize his wishes and to identify himself with his father. I have certainly succeeded in making conscious to the mother her permanent seduction of the little boy by showing her the danger of his dependence on her. She has given up hitting him but finds it most difficult to restrain him in less violent ways. She is reconciled to the idea of sending him to a nursery school, but we have decided to wait until Bobby himself asks to go. For four months in succession I have been able to show the mother that at each of her menstrual periods Bobby has either vomited at night or wetted his bed—otherwise he never wets now. Once at five o'clock in the morning he asked the mother to get out of bed at a time when she was menstruating and she is now thinking of asking her husband to make a bigger bed for Bobby, in order to persuade him to sleep on his own.

The treatment of young children gives a good opportunity for studying the conditions of character development. Even under unfavorable circumstances there is still a chance of influencing the development in these formative years. Without analytic help, Bobby would inevitably be heading towards delinquent character formation because of an over-indulgent, seductive mother and a weak father figure, constantly depreciated by the mother in the child's presence.

Could I have helped Bobby by seeing the mother only from time to time as is usual in child analysis? I am convinced that if I had separated

mother and child after the first introductory sessions, the mother's jealousy would have taken on proportions which would sooner or later have made the treatment of the child impossible. At best, she would have taken him away as soon as the symptom had disappeared. Or could I have helped the child by seeing only the mother in an advisory capacity? I do not think so, as her reports alone would never have shown what the child's behavior and play revealed in the analytic sessions. I have seen mother and child together for five weekly sessions over a period of three months and Bobby is now in treatment by himself for the third month. He will need careful guidance into the latency period.

CONCLUSIONS AND SUMMARY

It is more difficult for the mother of the young child to decide to send her child to analysis than for the mother of the latency child.

The mother of the young child in need of treatment can be helped in her decision by being invited into the consulting room for part of the treatment.

The mother is the most important person in the young child's life and her presence in the consulting room gives us a good opportunity to study the emotional interplay between mother and child and the ways in which it has contributed to the child's disturbance.

The mother who follows the treatment of the child in the consulting room will be better able to cope with the neurotic child at home and will gradually adjust her own educational ways to our analytic efforts.

The disturbed mother present in the consulting room can be given an outlet and yet be prevented from occupying the child's sessions with her own problems. She should be helped to recognize the implications of her behavior—but only with regard to the child and his disturbance.

For the child, the presence of the mother in the consulting room acts as a reassurance of her approval of the analyst and the analytic interpretations.

If the child's speech is still poor, the mother can act as an interpreter of the child's special language.

After some time, varying from case to case, the child develops a strong positive relationship to the analyst. The mother who has received some measure of satisfaction from being included can acknowledge this development as an achievement and on the basis of her attachment to the analyst will not unduly resent the suggestion to let the child try on his own.

Preparation of the mother for this separation forms an important part of this work. It should be gradually and carefully compensated by

interviews with the mother alone in which she is given detailed information of the progress of the analysis

After weaning the mother from the consulting room we still need her reports about the events occurring from day to day in the young child's life to enable us to understand his behavior and play during the sessions as his attempt to master external and internal reality. Thus the mother can still feel an active partner in the treatment although she is no longer in the consulting room during sessions.

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A TREATMENT OF NIGHTMARES IN A SEVEN-YEAR-OLD BOY

By LEO RANGELL, M.D. (Beverly Hills)

The following clinical experience is presented because it seems of interest for several reasons: (1) It shows in rather clear-cut fashion, a good part of the psychodynamic substratum in a typical case of nightmares in a young boy. (2) It made use of psychoanalytic thinking in a unique way. A son was treated by his father through the guidance of an analyst by letters. (3) It presents almost a verbatim, blow by-blow description of a psychotherapeutic interchange, with cause and effects nakedly outlined. (4) Implications can be drawn relating to the subject of transference in treatment, and also to the general question of the upbringing and education of children.

Some time ago, at my office here in California, I received word from a couple in New York City, close friends of mine for many years, regarding a problem with their seven year-old son. First I received the following letter from the boy's mother. (Comments appearing in brackets throughout these letters are my own, and have been added for this publication):

NEW YORK CITY
January 26, 1948

DEAR LEO,

Bill and I have decided to write this letter to you because we want to ask your help and advice, and also because we think you'd be interested in the problem we're going to tell you about. It concerns Paul

At the risk of writing quite a long letter, I'm going to start way back at the beginning when Paul first started to have nightmares, which was two years ago—just a few months after Anne was born. We spoke to you about it then—you gave us somewhat of an explanation. Somehow, they weren't too bad and as summer came on and he was outdoors a lot they must have disappeared quite a bit because I don't remember his being disturbed by them. However, as last winter approached so did the nightmares come on, and we all had a bad time because of them. Paul would awaken every night from a dream and would call to me in a voice full of fear. Most of the time Bill or I would go to him and lie down in his bed. If we didn't, he would lie awake whimpering with unhappiness and fear. He had very many colds which I felt were due to his unhappi-

ness at night and then he became painfully ill with swollen glands which kept him in bed about three weeks. It was during this time that we called John T. [a psychoanalytic colleague in New York] to ask his advice. He was very nice and when we told him the nature of Paul's dreams at that time of foxes and wolves pursuing him he said it was quite a typical case of an oedipus problem but that it certainly didn't sound bad enough to be treated. He suggested that we try to get from the library a paper by Freud, *The Analysis of a Phobia of a Five Year Old* in which the father of the boy with the help of Freud treats his son successfully. Bill made some attempts to get it but couldn't and let it go. Meanwhile I had asked John T. what he thought of our moving Paul's bed into our room and he said that although it might help we would be making him more dependent on us. However this was during Paul's illness and as the nightmares kept him up so much and he looked so wan I decided to move him into our room because I felt and still feel that half of his trouble is Anne—he does suffer because of everyone's attentions to her—and that by taking him into our room and leaving her out I was showing him that we love him that he was still our child. In other words give him a sense of security which he evidently needed—and lo and behold—the very first night Paul didn't awaken. He was in our room with nary a nightmare for about two months until spring and then we inveigled him back to his own room with Anne. Soon summer came. We went to the country where we had a two room bungalow. We all slept in the one bedroom. Paul had a wonderful time all summer. When we came back it had gotten to the point where I could even shut his bedroom door when he went to sleep and I remember even writing to you about how happy I was that Paul had gotten through that difficult time. I was too hasty in my relief however because since then—about two months ago—Paul has awakened every night at least once in a state of fear or anxiety. In the beginning he asked me to sit on the couch where he could see me until he fell asleep again. This I did. However some nights when I was particularly groggy or tired I would foolishly decide to be stern and say that he would have to lie there until he fell asleep again—on those nights he would lie awake hour after hour and call me four or five times on some pretext or other. He would then fall asleep towards morning and would have to go to school overtired and unhappy. This brings up another important point. For the last few months he has taken a dislike to school whimpers must I go? gets terribly cold shivers etc. in other words shows manifestations of nervous tension. He happens to be one of the brightest children in the class gets an honor report card signed by the principal behaves very well and is very well liked by his teacher. I feel one reason for all this is his dislike of leaving me at home with his sister while he goes off. One indication of this is that he has had two very unhappy severe diarrheas in school in which he did not get to the bathroom in time. Of course the thing is a vicious cycle for

this in itself may be a reason for his disliking school, his fear of not getting to the bathroom in time

Another very important thing that has happened is that six weeks ago or so, he started to have trouble with his stomach (He has had for a few years at least a "sensitive" stomach, a lot of foods it seemed would upset him and his diet was always a simple one for fear of his getting a loose stomach. I even remember telling the doctor about his extremely large B M's and he told me at that time if nothing accompanied it that it was nothing.) Every three or four days he would have loose bowel movements sometimes with cramps, sometimes only a movement of large strings of mucus. We tested his stool for bacteria, etc., and found it negative, and then I used Kaopectate (a medicine intended to put a lining on the B M.) Still it didn't help. Then we started working on the theory that it might be an allergy and for four days I kept the poor kid off all wheat—no help. For the past week and a half, I've kept him off all vegetables and juices. Everything was okay until Saturday when he had three bad bowel movements with cramps. I had given him salmon which he may be allergic to, if he does have a food allergy. But, I don't know but that this whole thing is not an emotional problem, and that is why I am writing to you. If it is I feel something ought to be done. I'll tell you what we've done already. Last week, Bill finally found the paper John referred to. It's not allowed out of the library. Bill is reading it and telling me about it. It has helped somewhat in that we're doing something constructive. We're attempting our own amateur analysis of Paul's emotional life based on the pattern followed by Hans' father. Bill has kept a daily account of the pertinent material which we are enclosing and which we will send to you as our analysis progresses.

We have a specific question however on which we would like your opinion. Should we solve all this sleeplessness at one stroke by the simple device of putting Paul's bed in our room, thus giving him some much needed rest, and maybe helping his stomach by eliminating his fearful dreams? Or, shall we continue our efforts (which don't seem very fruitful as yet) to get at the root of his anxiety while he stays in his own room and continues with his trouble?

As I reread this it occurs to me that you might get the picture of Paul as being a depressed, morbid and moody child. On the contrary, he is still the bright, outgoing, social, witty and happy appearing child in company as you remember him. What I described above, are only the characteristics of his bedtime and pre bedtime behavior and his appearance during the night.

Bill has been meaning to write to you about this for a long time now but he has been very busy in his work. We know that you are very busy but we feel that you will want to know about Paul and we want to thank you for the time and effort that we are asking you to spend on our problem.

As ever,
LENORE

A day or two later, as promised, a follow up letter arrived from Paul's father as follows

NEW YORK CITY

January 28 1948

DEAR LEO

When I talked to John T. about Paul last year he suggested that I might be able to handle the problem by following the pattern set by Hans' father in Freud's paper "Analysis of a Phobia in a Five Year Old". I have been reading the paper in the library and have been making efforts at analyzing Paul along the lines indicated. Enclosed are the first notes I have made. We don't seem to be getting very far yet but at least we've gotten Paul to talk to us about his fears and to get them out into the open. I don't feel however that he is telling us all he dreams.

He is still very reluctant and appears to be holding back. I would appreciate very much your comments and advice. With your help (as Freud helped Hans' father) maybe we can get somewhere. [The flattering ing analysis did not fail to have its effect!]

Again thanks for reading this stuff and let's hear from you

Yours

BILL

The following notes were enclosed with the letter

January 20 1948

Paul awoke in the middle of the night as he has done almost nightly for the past few months and cried out for us in a voice mingled with fear and entreaty. I went to his bed in the adjoining room and found him with that pitifully sad look, his eyes wide and on the verge of tears. He was very morose and reluctant to talk but indicated he wanted me to stay with him or at least to sit on the living room couch where he could see me so that he could go to sleep better. I asked him what the matter was. No answer. Did he dream something? No answer. Was he afraid? No answer. I explained that I was trying to help and that if he told me about his dreams or his thoughts or his fears I might be able to help him to get rid of what was bothering him so that he would be able to sleep through the night and feel rested for school the next day. At length he said he had dreamed something. You know the same thing about animals in the jungle. What kind of animal? No answer. Was it a wolf or a fox? FOX he answered in a whisper spelling out the word. What about the fox? No answer. What was he doing? No answer. What did he look like? No answer. Did he look like daddy maybe? [Paul's father learns fast! This is known as the direct frontal attack.] A wide ear to ear grin replaced the morose look on Paul's face and he lifted his head from the pillow to say loudly this time "Are you kiddin'!" I "Why can't you sleep now?"

PAUL I keep thinking about the dream and it won't let me sleep
 I 'Tell me more about the dream No answer
 I What's in your mind now? What are you thinking about?
 PAUL (In a very low whisper) An eraser
 I What about an eraser?
 PAUL 'Nothing I was just thinking about it

He was getting very sleepy and I returned to my bed. He cried out a few minutes later again and Lenore went to him and slept with him the remainder of the night.

The next morning at breakfast Lenore and I explained to him that we were both going to help him get rid of his fear that there were special doctors like Leo who do that sort of thing but that we were studying from a book and would be able to help him just like a doctor would that we wanted him to help by telling us all about his fears and dreams and thoughts which we would be able to understand and explain to him. We said that we both loved him were not angry because of his fears and insomnia and would be able to help him sleep through the night without bad dreams if he co-operated. Paul agreed.

I asked again about last night's dream. Paul couldn't remember.

I What about the eraser?

PAUL Oh I dreamed that there was a squirrel and an eraser up in a tree and a fox came along and the squirrel threw the eraser down on the fox but that didn't hurt the fox so the squirrel jumped down from the tree onto the fox to fight him.

(I interpreted this as follows: Paul was the squirrel and with the eraser he tried to rub out—or get rid of—the fox who represents me his daddy. Not being successful he jumped down to fight with me himself.)

I suggested this interpretation. Paul laughed seeming to enjoy it immensely.

I What did the fox look like like me maybe did he wear glasses?

PAUL (sarcastically) Oh sure he wore glasses and a blue suit, and a red tie and a white shirt just like you (describing exactly what I was wearing at the moment)

I explained that Paul might dream of me that way because he thought I might be angry with him but that I really was not and on the contrary that I loved him very much.

PAUL Oh I know you're not angry with me I know you love me

Later Paul said that maybe he was the squirrel
 As he left for school I said Goodbye little squirrel

He answered "Goodbye you great big fat fox!" and left for school in better spirits than we had seen him in a long while and without ex-

pressing concern about his bowel movements (also for the first time in many weeks).

["Fools step in where angels fear to tread." Where a more experienced therapist would wait and exercise caution and restraint, Paul's father, unmindful of the possible consequences and therefore in a sense unfettered by them, jumps in with both feet. It worked. Paul immediately perceives his father in a new role, and unconsciously senses the possibility of a new outlet for dammed-up instinctual energies. His mood lightens, he grins, his spirits lift.]

January 21, 1948

Paul called out twice in the night, but on each occasion he called once, and on receiving no answer, remained silent and went back to sleep. In the morning, he was very cheerful (unusual) and said "Wasn't I a good boy? I slept all through the night"

I. "No dreams?"

PAUL. "No I slept all through the night"

January 22, 1948

Paul awoke twice during the night, and didn't sleep well until Lenore slept with him. He would not elaborate on what kept him up, except to say that he had the same dream 'about the jungle and animals"

January 23, 1948

Awoke again. This time I slept with him until he fell asleep again. Nothing from Paul except that the same dreams keep him awake and afraid.

January 24, 1948

Awoke again. I went to him. Same dream, he said. He also mentions that this time he dreamed of a gorilla who led all the other jungle animals, lions, tigers, foxes, wolves, in their chase after him. The gorilla got closest to him, with his mouth open. "What did the gorilla look like?", I ask. "Like a gorilla," Paul answers. "I suppose you want me to say he looks like you!"

The next day, Paul told me about first thinking of the gorilla after seeing one in a movie in camp this past summer. (In fact, we all saw this film together, last summer in the country—a ridiculous Mack Sennett comedy in which the Our Gang kids chase a gorilla around, and vice versa.)

I. "Did you dream about the gorilla in the country too?"

PAUL. "No—because I slept in the same room with you and Mommie there"

(We had had a small bungalow in which all our beds were in the same room)

Paul then suggested that he would be able to sleep well all night if we moved his bed into our room (We had done this last year for a short time when the same fears had been present)

I evaded by saying that it would spoil the looks of the apartment, and that Annie, who is a little older now, would not like being left alone in the other bedroom

I should also note that Paul is fearful even before his bedtime and forewarns us that one of us must sit in the living room where he can see us from his bed so that he can fall asleep more easily. He thinks he says of the dreams he has had and those he is going to have, and just can't get the animals, the jungle, etc., out of his mind [Phobia for sleep itself, and its products]

January 25, 1948

Paul awoke again in the middle of the night and I went to him. At first he was reluctant to talk, denying that he had had any dream but after a few minutes said that he had dreamed of the gorilla again

PAUL: "The gorilla was chasing me through the jungle. I ran and just reached the ship in time"

I: "What ship?"

PAUL: "The ship to go back to America. It was the Queen Elizabeth. Did you hear on the radio that the Queen Elizabeth was stuck in the ice yesterday?"

I: "No, I didn't hear. What else did you dream of?"

PAUL: "The gorilla jumped after the ship and caught on to the back end. But the ship went too fast and he fell into the water"

I think it in order at this point to discuss my initial reactions to these first communications, and to the unusual and unconventional proposal for treatment which they contained. Clearly, there was a neurotic symptom present which by its content, intensity and duration demanded analytic treatment. Routinely and ideally, referral to a child analyst was in order. This simple move, however, as is so often the case, was ruled out promptly for economic reasons. Treatment in a clinic was the next logical thought, but previous experiences made me dubious about the prospect of securing adequate analytically-oriented treatment in this way. This avenue is unfortunately discouraging at the moment. While aware of the dangers inherent in the method proposed by Paul's parents, their request nevertheless intrigued me. There were several important factors in favor of trying it, high among which was the fact that I was strongly and personally motivated by my interest in them. The dangers that I might be working blindly, at a distance, and with insufficient control of the situation, were offset in my opinion by my previous first hand knowledge of the background and my confidence in the parents. Nor was the tempungly

promising beginning already made by Paul's father to be overlooked. Accordingly, it was decided to attempt the treatment in the manner proposed.

Let me interrupt at this point to orient the reader with a few pertinent remarks about the past history as I knew it. At this time Paul was seven years old, a bright, active and robust youngster. His parents were warm, intelligent and sincere people, much devoted to and proud of Paul and his sister. His mother had had some chronic anxiety and neurasthenic symptoms of her own, which she tended to displace onto Paul, leading to overprotection and overconcern about what he wore and ate, etc. This had always seemed to be a large factor in the production of the frequent colds, or sniffles or tummy aches which Paul would get at strategic times in his life. The father was an energetic young business man, warm, a loving and permissive parent, perhaps somewhat overindulgent. The home atmosphere was harmonious. It is of interest for what follows to state that the parents have had no connection with or background in analysis or medicine except for social relationships with a few analysts and a slight amount of reading in the field. At about one and a half, Paul had a fractured clavicle. At three and a half, a heart murmur was discovered which, although finally diagnosed as functional and of no significance, caused a natural flurry of excitement and concern about him. At four and a half, his only sibling, his sister Anne, was born, with no unusual attendant reaction on Paul's part other than stated in the letters.

My first letter in response to their request follows. These letters were written in an unplanned and spontaneous way, much as one responds in a direct psychotherapeutic situation. They will be reproduced here in the same informality and spontaneity in which they were written, to preserve better the tone of the relationships involved.

BEVERLY HILLS CALIF
February 4 1948

DEAR BILL AND LENORE

Of course I'll do anything I can to help—I only hope that my eagerness and concern doesn't impair my judgment. Here is a hurried note to give you some of my preliminary reactions.

1) The whole thing is one problem: the nightmares, diarrhea, stomach trouble, concentration on the bowels, attitude towards school, shaking and quivering, etc. The intestinal symptoms I am sure are emotional in origin; the bowel symptoms are what we call regressions due to the phobia. Therefore

2) I advise stopping completely all emphasis on stomach trouble, diet, bowel movements, etc. Discontinue visits to the M.D. Feed him anything he likes. Be casual about his bowel movements, whether they are one in two days or three per day. Forget about allergy completely. [With

all due respect to allergists I felt I knew enough about past similar symptoms with Paul to make this seemingly dogmatic statement with confidence]

3) The method you propose is very difficult, and has numerous obstacles and drawbacks For the time being however let's try it. From my standpoint, it's 100 per cent okay and I'll do all I can The difficulties are in the distance between us that it will be hard to keep current and that I'd have to tell you and explain to you much more than I can ever write However your preliminary attitudes on the problem are whole some (The last resort to be kept in reserve which I would recommend immediately if the money question didn't enter would be to put the entire thing into the hands of a good child analyst in New York We'll put that aside for the time being however and work this way)

4) I think the rivalry with Anne is a secondary problem I think the crux is a parental oedipus problem

5) Do not under any circumstances yield to the temptation to put his bed in your room Also please try very very hard not to sleep in his bed (either Bill or Lenore) It is all too stimulating to him and perpetuates the problem Sit up next to his bed when put to the task and make repeated attempts to return to your own room However

6) Not harshly or critically Always be reassuring repeat your love to him (Don't overdo it though and make him wonder why you say it so much)

7) Encourage him to talk and to reveal as Bill did in the notes One caution the interpretations so far were good but don't make too many seemingly outlandish suggestions Let him lead the way—you follow You may have to push and encourage now and then but mainly let him take the initiative with you encouraging him The eraser and squirrel and fox—was excellent (So was his response to it as you noted)

8) Answer all his questions about sex truthfully—don't evade—but be simple—and don't tell him more than he asks

9) The ship dream—the Queen (Elizabeth) was Lenore—he wanted to get on her and be off—you the gorilla (Bill) came along and jumped on her back (probably his conception of intercourse—the many months in your room play a big part here—he must have many ideas and feelings about this right and wrong ones)

10) Keep the notes coming I'll write you as often as I can

Yours
I FO

A few days later I heard again

NEW YORK
February 9 1948

DEAR LEO

Thank you for your letter the warm interest you have shown and the help you have already given us

Unfortunately, your advice arrived just a few days late and did not prevent us from making what now appears to have been an error in judgment. Just two days ago Saturday night we took the path of least resistance and gave in to Paul's repeated pleas we moved his bed into our room. He had not had a decent night's sleep in weeks he looked groggy and tired each morning before school he was suffering with a cold and seemed unable to shake it off and Lenore and I were anxious for a night's uninterrupted rest ourselves. So we agreed to Paul's suggestion with the understanding that this would be temporary and that he himself would ask us to move him back to his own room when he felt ready for it. Since then he has slept better acted better during the day and even improved in his bowel movements. He does get up sometimes he says but when I see you I feel better and go right back to sleep. Since then also I have secured very little material from him—no dreams no thoughts no discussion (The enclosed material was before we moved the bed).

For some time now Paul has been asking us for a dog. He even thought he might be able to sleep better with his own dog staying in his room. We had not accepted the idea because of our small apartment the trouble involved etc—but now we are using this as a means of retreating from our mistake. Paul has agreed that if I get him a pup he will return to his own room gladly. We shall see.

Meanwhile I feel that we are almost at a standstill. Since the material that I am enclosing I have gotten nothing from Paul. As you can see even before receiving your letter I was reluctant to force the issue—waiting instead for Paul to lead. Question is how does one encourage—or do I just wait until he is ready again to give out? [Bill's query can well be identified with by every dynamic psychotherapist who recalls his own development in the field.] About sex Paul has asked almost nothing at all about sex since last year when he was given on his request pretty detailed information. We had been on the beach last spring and met there a young mother with a famous set of quadruplets. On our way home Paul remarked 'She must have had a lot of seeds' and later

Her stomach must have stretched a lot when she was pregnant! That evening he brought the matter up again and asked Lenore where the seeds come from how they get into the mother who puts them there how and how do the babies come out. Lenore answered truthfully and without fuss the seeds are placed by the father through the vagina with his penis and the baby comes through the vagina. Paul laughed and remarked that the penis works just like a rubber hose. At that time Paul was well and happy and not having nightmares. Since then no questions at all on the subject have come up.

Thanks again Best to all

BILL AND LENORE

The following notes were enclosed with the letter:

February 4, 1948

Paul has shown no improvement whatever. In fact, he seems to be worse. He has awakened every single night without exception, fearful, and begging for our company. He denies that he has had any dream, on occasions saying that he just wakes up and is "afraid." If he does dream, he says, it is "the same thing . . . animals and jungles."

Lenore reports that this afternoon (he has been home from school the past few days with a cold), Paul began a conversation by asking about Lenore's parents. When did her father die? How old was he? How old was Lenore at the time? How old was her mother when she died? How old would her father and mother be now? Lenore answered all truthfully, stressing that her parents died when they were very old, that she, Lenore, was a grown-up when they died.

Later on during the same afternoon Lenore noticed Paul looking sad and unhappy. Asked whether anything was the matter, Paul said, "I have a headache. You know, I often have headaches in school. I have to work hard, and I have a headache, when I want to be home with you." [How clearly and unpretentiously Paul describes a conversion symptom.]

Paul was moody and dejected all day at home, and had several crying jags, for no apparent reason.

February 5, 1948

Paul awoke during the middle of last night and I went to him. He began to cry when I talked to him, would not answer my questions about what was bothering him, and seemed more unhappy than ever. He sighed deeply, his chest heaving, tears welling up into his eyes, and sobs, suppressed, coming up from way down. He had nothing to tell me. I stayed with him until he fell into an uneasy sleep. He awoke again some time later, and Lenore spent the remainder of the night in his bed.

This morning he awoke unhappily, very ill at ease, and crying at the slightest provocation. I tried talking to him again, asking him to confide in us, to tell us his troubles. He only cried more, sobbing as though his chest would burst. This was the most severe unhappiness we had ever seen in Paul. I said: "I think I know what's wrong, Paul. You're worrying about something. You have bad thoughts, maybe, and you're ashamed of them, or guilty about them, and you're too ashamed to tell them to us. But you don't have to be. We love you and we understand that little boys sometimes have these worries. Tell us about them and you'll see that we are not angry or ashamed and that you have nothing to be ashamed, or guilty, of." Paul continued to sob. A few minutes later he calmed down somewhat and I asked when he thought his fears about sleeping alone began.

PAUL: "A long time ago, when Anne was in your room, in her crib, and I had the other room by myself."

I Did you perhaps have bad thoughts about Anne at that time?

PAUL Getting tearful again nods assent

I Did you wish that she would go away?

PAUL Nods yes

I Or maybe that she should never have come in the first place?

PAUL Nods yes again

I Or maybe that she should die and go away?

PAUL Nods agreement again now unable to prevent tears once more

I Mommie and I understand why you felt that way Paul and we are not angry with you because of your thoughts You know I think that all your bad dreams are your own way of punishing yourself for your bad wishes about Anne You feel ashamed and guilty of the wishes you had toward her and so you punish your self with frightening dreams about animals But you don't have to punish yourself because there is no reason to feel ashamed or guilty about anything

Paul calmed down and stopped crying (I feel sure that Paul's suppressed hostile wishes are also directed against me but I don't know how to proceed to bring this out)

In the evening after returning from work Lenore reports that Paul had mentioned during the day that he was also worried that I might die or might not come home from work some day Paul talked with me in much better spirits and happier than this morning He said that he was worried that I might die before I was an old man or might not come home from work some day I assured him that this was very unlikely that I was young and healthy would always come home from work and wouldn't die until I was an old man and he a grown up old man himself I asked whether he had ever wished that I would go away and leave him alone with Mommie Oh no he replied (Although Hans father in Freud's case plunges right into this sort of situation with questions aimed at bringing the child's death wishes toward his father out into the open I am afraid to proceed along such lines and therefore dropped this questioning on Paul's first negative answer) [Who can blame him?]

BEVERLY HILLS CALIF
February 16 1948

DEAR BILL AND LENORE

On your second installment concerning Paul some comments

1) Can't blame you for giving in and taking him into your room—his entreaties must be pitiful—but do try to undo it and get him back into his room for good Talk of the whole house as one room it all belongs to all of you you're all together etc But insist on your sleeping arrangements Don't evade it as you did in installment one with remarks about the apartment looking better the other way etc You've got to be truthful with him—remarks as the above cause you to lose face and

- I: "Did you, perhaps, have bad thoughts about Anne at that time?"
 PAUL: Getting tearful again, nods assent.
 I: "Did you wish that she would go away?"
 PAUL: Nods yes.
 I: "Or maybe that she should never have come in the first place?"
 PAUL: Nods yes again.
 I: "Or maybe that she should die and go away?"
 PAUL: Nods agreement again, now unable to prevent tears once more
 I: "Mommie and I understand why you felt that way, Paul, and we are not angry with you because of your thoughts. You know, I think that all your bad dreams are your own way of punishing yourself for your bad wishes about Anne. You feel ashamed and guilty of the wishes you had toward her and so you punish yourself with frightening dreams about animals. But you don't have to punish yourself, because there is no reason to feel ashamed or guilty about anything."

Paul calmed down and stopped crying (I feel sure that Paul's suppressed hostile wishes are also directed against me, but I don't know how to proceed to bring this out)

In the evening, after returning from work, Lenore reports that Paul had mentioned during the day that he was also worried that I might die, or might not come home from work some day. Paul talked with me, in much better spirits and happier than this morning. He said that he was worried that I might die before I was an old man or might not come home from work some day. I assured him that this was very unlikely, that I was young and healthy, would always come home from work and wouldn't die until I was an old man and he a grown up old man himself. I asked whether he had ever wished that I would go away and leave him alone with Mommie. 'Oh no,' he replied. (Although Hans' father, in Freud's case, plunges right into this sort of situation with questions aimed at bringing the child's death wishes toward his father out into the open, I am afraid to proceed along such lines, and therefore dropped this questioning on Paul's first negative answer.) [Who can blame him?]

BEVERLY HILLS CALIF
 February 16, 1948

DEAR BILL AND LENORE

On your second installment concerning Paul, some comments

1) Can't blame you for giving in and taking him into your room—his entreaties must be pitiful—but do try to undo it and get him back into his room for good. Talk of the whole house as one room, it all belongs to all of you, you're all together, etc. But insist on your sleeping arrangements. Don't evade it as you did in installment one with remarks about the apartment looking better the other way, etc. You've got to be truthful with him—remarks as the above cause you to lose 'face' and

prestige with him—he'll always take the truth better than anything you can make up. A good way to work out of this would be through:

2) The dog—I am in favor of it, if it is feasible and practical with you and Lenore. It can help—but only if it isn't too much for you in the house.

3) About your being at a standstill—don't worry. In the first place, you are not, things are happening. Secondly, there are stops and starts, and different paces, as he gains courage for new statements and feelers. Just wait, and reassure, and encourage him to talk.

4) About sex—Lenore's answers a year ago were good. There must be more questions though. Watch for them, and answer in the same way—no fuss, no lies, no evasions.

5) His preliminary questions about Lenore's parents (Feb. 4) were the tentative beginnings of bringing out such thoughts about his own parents.

6) His headaches (as described) are beautifully diagnosed by himself—"When I want to be home with you (Lenore)." I think his frequent colds (and I mean for years, not just now) are similarly used and even possibly originated (with all due respect to the New York winters). Pay little attention to them unless accompanied by fever, etc. Let them disturb his going-out routine as little as possible, not at all if possible.

7) Bill's remarks to him (at his moments of greatest unhappiness, Feb. 5) about "I know what's wrong, you're worried about something, ashamed and guilty about something, you don't have to worry, we accept and love you anyway, etc.," were very well put. It brings immediate response from Paul. Then came his revelations about Anne, and then about "Bill might die."

8) Bill's direct question then "Did you ever wish that I would go away?" drew a negative reply. It would have been better, instead of asking, to say some such thing as, "Sometimes children are angry at their daddies and might for some reason wish such a thing"—in a way which makes the thing understandable and not punishable—more will come from him then about it spontaneously.

You're not at all at a standstill. You're on the track, keep him talking, and keep up this general tone with him.

Best regards,

As ever,
LEO

NEW YORK CITY
February 19 1948

DEAR LEO,

Enclosed find my latest notes on Paul written after a lengthy conversation with him last night.

At this point, Leo, I must say that I feel unsure of myself and uneasy over developments. The thought plagues me that, on occasion I

do more harm than good, that I may be opening something that I'll be unable to cope with. Take last night's conversation, for example. When we began, Paul was in good spirits, he had had a happy day, he had slept well for many nights, bowels O.K., school O.K. he was willing to talk. The squirrel fox dream had caused him no unhappiness or fear, and he related it simply and straightforwardly, smiling as he talked. As we talked about it, however, and after I had outlined the underlying oedipus pattern, Paul changed, became depressed, reluctant to talk, and finally fearful and in tears. Of course, I reassured him as best I could. But I remain doubtful. Was it correct to explain the dream and its oedipus pattern to him? Or, in doing so, did I implant, or reinforce, his feeling of guilt, and consequently of fear? The analysis caused him to admit hostile wishes against me, which caused him to cry and then to fear the fox's punishment. I had the feeling that my assurances were not fully accepted or believed that Paul was stunned by the realization of the truth of the oedipus picture and that, having had hostile wishes against me, he now feared the inevitable punishment. He had a bad night in consequence and awoke this morning on the unhappy side. Question: Is it proper to explain to Paul the meaning of his dreams taking the risk of forcing him to unpleasant and emotionally disturbing conclusions? Or should I have waited? Is there value in my just listening to his dream content without analysis?

(Cont.—February 20 1948)

On arriving home last night I found your letter which by indirectness answered some of the questions above. I would find it very helpful however, if you answered them directly in your next reply.

Lenore asked me to tell you that she is following your suggestions. No M.D. visits no fuss about B.M.s no more dieting no notice of colds etc. Again our profound thanks for your wonderful co-operation and help.

Our very best to all of you

BILL

Enclosed were the following notes

February 8 1948

Moved Paul's bed into our bedroom

February 18 1948

Since Paul has been sleeping in our bedroom he has slept better acted happier and has shown a remarkable improvement in his stomach condition. No cramps or diarrhea and no worry about too frequent B.M.s. He doesn't have many dreams, he says. Sometimes he gets up at night, but when he sees us close by, he is not afraid and goes right back to sleep.

A few days ago, he reported this dream. I was riding on the back of a horse and the horse turned around and kissed me. What did the

horse look like? "I think the horse was you, Daddy. He was wearing the same kind of coat that you and Mommie have" (Both Lenore and I recently bought overcoats with fur collars, almost identical in appearance)

Tonight I was home alone with the children, Lenore having gone off to the movies. Paul appeared in good spirits and I asked if he wanted to talk with me again about his dreams, or his thoughts. Did he think he could try to sleep in his own room by now? He agreed that he would, just as soon as we bought him a dog, as we had promised about a week ago. About dreams, he reported the following, occurring several nights ago: "A squirrel was up in a tree putting his nuts into his hole for the winter time, when one of the nuts fell and hit a fox on his nose. The squirrel jumped down to get the nut and grabbed it in his mouth, where upon the fox chased him deep into the woods." This reminded Paul, he said, of the other squirrel dream. This time, he said, he thought the fox looked like Mommie. In the first dream, it had looked like Daddy. He thought that he was the squirrel both times. We talked about the dream and what it might mean, and I asked if he remembered what I had said about the last squirrel fox dream. He said he remembered a little, but wanted me to repeat. I explained, as I had done before, that the animals were symbols representing me and him, that he dreamed of being punished by me (the fox) because he felt guilty of wishes that he may have had toward me at some time in the past—that these wishes sprang from rivalry with me in reference to his mother's love. I assured him that these wishes and thoughts were natural and normal and that both mother and I understood and had no anger towards him and loved him dearly. I suggested that if he understood this clearly and accepted it he probably would not be afraid, or dream of the fox any more. Paul replied that he had bad wishes against Mommie, but not against me. He wished sometimes that Mommie would go away, or not come back, or die, so that we two could be together, like tonight—not the other way around. Then he said that at one time he did have wishes against me, but not now. "You remember," he said, "when I was crying that time and I told you about it." (He was referring to the time when we had talked about Anne.) "I thought you had said it was Anne that time," I said. "Oh yes," he replied, "it was Anne, not you."

I "Maybe it was about me too."

PAUL. "Yes, I think so, I had bad wishes about you too, but long ago—not now."

Paul was reluctant to talk further. He had grown more and more unhappy during this discussion, and was now on the verge of tears. When I asked what was making him cry, he said that it was true that he had had bad wishes against me and that it made him feel like crying. I assured him again that I understood and loved him. He finally fell asleep.

Comment Paul was probably telling the truth. The horse he was astride this time was the father, who gives him the reassuring and loving kiss. The threatening fox, formerly the father, is now the mother. Both parents wear the same coats. Hostile death wishes toward Mommie, the wish to be left alone with father, are admitted, and later, more reluctantly, the same bad wishes toward the father. Paul is describing his negative oedipus complex, the boy's tender love for his father, for whom it is his mother who is the rival. This does exist especially with his good permissive, understanding father, and in fact makes more poignant his conflictual relationship toward his father. This negative side of the oedipal coin comes out first, and is actually also a sop to the father. Behind it, there comes out of repression, amid tears and anxiety the positive oedipus, with the painful admission of bad wishes toward the father—but long ago.

What about the father's quite understandable trepidation and anxiety at this point? Was it an indication of things having gotten out of control and should it have led to an abandoning of this treatment? On the contrary, was it not the natural and predictable reaction to the unconscious material which was emerging the same resistance in miniature, which one finds in more chronic form in a more prolonged analytic treatment? It was, in fact, a resistance *à deux*, the cumulative anxiety and subsequent resistance of both father and son to the same material. The reactions of both had to be dealt with.

BEVERLY HILLS CALIF
February 24 1948

DEAR BILL

Received your letter today. Some comments.

1) You're doing your job well. Take heart. You are in the unfortunate position of dealing with your own son and therefore wincing with each pain which he feels. Of course too much anxiety is to be avoided and is a sign to stop or pull back. But in general the mobilization of some anxiety during this period cannot be avoided and even keeps the entire process moving. As a whole you write of better days and nights, better spirits in Paul and less physical symptoms. So don't become upset by it. Also in general you're doing what it takes a psychiatrist years to learn and I think doing it well.

2) I acknowledge Lenore's message—good—keep it up and try to be consistent about this—less attention to and fuss about his physical ups and downs.

3) Just listening to the dreams without analysis is sometimes of help in itself—of course if one doesn't understand the meaning there should be no spoken analysis—if one does understand the interpretation if given should be cautious and tentative and not dropped like dynamite.

I don't think you've overdone it. When in doubt, though, just listen, encourage and reassure.

4) Keep trying to get him back to his room—follow through on your promise of a dog if you can.

5) The horse kissing him—you. Overaffection, and kissing him, and bending over backwards in your concern (which he can sense) can even increase his guilt. He feels that he is so bad, deserves the worst, and gets such kindness; this may worry him. (This is just to be noted and perhaps watched—don't let it confuse you, though, in your attitude toward him.)

6) The squirrel-nuts-fox dream—very interesting. Has to do with his fear of losing or dropping or damaging his nuts (testicles—genitals)—castration fear—probably because of his putting them in the hole (mother's). This information is for you, not for him. He might some day give a better opportunity to bring up the question of fear of damage to his genitals.

7) Don't initiate the discussions now of his hostility to you, proof of which is certainly blatant and undeniable—he might feel you're pressing it and therefore be frightened—but take it up and recognize it and reassure him at any indication he gives about it. He also loves you—very dearly—tell him that too when he shows it—tell him both feelings are there, are mixed and are natural.

8) Have courage—take your time—don't worry. When he becomes upset and tearful, remember that misery and tears have been a regular nightly occurrence for many months, when no attempt was being made to understand them—so an occasional episode like that now is not a heavy price—if it is on the road to progress—which it can very well be.

Yours,

Leo

It was now a full month before the next communication was received:

NEW YORK

March 23, 1948

DEAR LEO,

I haven't written for this long interval for very happy reasons: I have no notes to send; Paul is a thousand times better in every way; we have had no direct pertinent conversations to be recorded. Let me bring you up to date.

1) We carried out our promise of a dog for Paul with wonderful results. Paul, without the need of any urging from us, carried out his end of the bargain and promptly moved back into his own room. (He had been in our room for just one week.) Since then he has awakened during the night on occasions, but the quality of his behavior on these occasions has changed: he is no longer overfearful, teary, and sweaty. He simply asks to be covered, or to have the light on, or to have me sit in the parlor

where he can see me for a little while I do what he asks and he generally falls asleep very soon—in a matter of minutes. He says that he has had no dreams, or has forgotten them, or has been awakened by noises or by the covers falling off, etc. Of late, his awakening at night has become less and less frequent. He never asks me to sleep with him any more. Most important, his entire demeanor is happier and normal upon awakening.

2) His stomach condition has entirely disappeared. There have been no abnormal B M's, no diarrhea, no constipation, no fears along these lines for a long time. Paul is very happy about this and proudly told his M D that his stomach was cured. (His pediatrician is a very nice fellow, to whom I described some of the things we've been doing. He agreed and said he'd thought Paul's trouble may have been emotional from the beginning.)

3) Interesting confirmation of your analysis of the ship dream (your letter of 2/4/48). We were having breakfast one morning a few weeks ago, the whole family in a sort of gay mood, and I remarked to Lenore, "You're looking fine this morning, Lenore, very lovely—to which Paul rejoined, 'Aaah, she looks stinky!' What does she look like, Paul?" I ask, "Like Queen Elizabeth," he replies. "You mean the ship?" asks Lenore. "Naah, crazy, like the Princess, the Queen of England you know," Paul answers!!!

In general, the sleeping stomach, school, Paul is a thousand times better. I ask him from time to time if he wants to talk about things, about his former fear, or any questions he might have on his mind, but he answers in the negative. So we've had no more conversations. I don't press the issue of course, and since he seems to be so much better and improving steadily, I do nothing but watch, reminding him on occasion that I'm still around to talk about these matters whenever he chooses.

You've been a wonderful help through all this, Leo. In fact I would never have begun without your guidance and support, and we cannot thank you enough.

Best of everything to all of you from,

BILL AND LENORE

P S The family is well. Anne, a wonderful, charming, lovable creature, Lenore is well,—and all of us are looking forward again to the summer. We're going back to the same colony where we had such a good time last year. Our dog is a cute little pup, part Terrier and part Beagle Hound. We call her George, because we got her on Washington's birthday. Paul and Anne love her, and even I am becoming something of a dog lover myself.

Comment: Some might be inclined at this point to attribute the improved state simply to the acquisition of the dog, following "post hoc ergo propter hoc" reasoning. While this may be a temptingly direct way of

thinking, it would be an oversimplification of the facts and would indeed do injustice to the basic emotional alterations taking place here. The appearance of the dog on the scene did no more to remove the nightmares than its absence did to produce them. On the other hand, dynamic therapy does not spurn aid from any direction. Paul was ready at this point to shift his attention and libido to this new object and even, to an extent, to "save face" with it.

The dynamic forces and tensions within the various mental agencies, in constant balance, do not realign themselves in one lightning stroke and land with a thump in a new fixed and permanent pattern. Rather they swing in a pendulum-like motion and only gradually do they alter their resultant direction under the pressure of forces applied from without. The new status described by Paul's father was gratifying; however, one could expect some fluctuations to occur before this became a secure and solid position. Newly formed scars need protection and are still vulnerable.

BEVERLY HILLS, CALIF.

March 26, 1948

DEAR BILL AND LENORE,

Needless to tell you how glad I was to receive your letter of yesterday, and especially with its contents. I was quite worried about the long silence and hoped it wasn't a sign of some discouraging developments. I was about to write you when your letter came.

The results are even more than I had expected, at least so soon. I wish you would drop me a progress note every couple of weeks or so just to keep me in close contact with the status. What you're doing is right—just a normal attitude now, not pressing, happy at the results, and ready to hear and see if anything more comes up. I'd like a few more months to go by this way before feeling completely that this is now a thing of the past.

The confirmation of the Queen Elizabeth dream certainly is interesting. Also I'm not surprised at the bowels and stomach clearing up along with the fears.

So—keep me posted.

As ever,
LEO

A month later:

NEW YORK CITY
April 26, 1948

DEAR LEO,

Just a progress note to let you know that everything is fairly smooth with Paul. That is not to say that we think that he has resolved com-

NEW YORK, N Y

May 21, 1948

DEAR LEO,

There is nothing to report about Paul at this time. Everything is about the same. About this summer, however, it looks as though we will all be sharing the same bedroom, as we did last year. We have a small cottage, with only one bedroom and any other arrangements are practically impossible. It would, further, be very queer to Paul if we were to insist on crowding him into the very small kitchen (and leave Anne's crib in our bedroom to boot). So it looks as though we'll have to take our chances with the one bedroom setup. Things are smooth now and maybe by summer the danger will be mostly passed, anyhow—what do you think?

Paul awoke one night a few weeks ago and said that he had had a bad dream. He had gone along with me to the office and somehow lost me in the subway. He was panic-stricken upon not being able to find me and awoke in fright. We didn't discuss this as he looked sleepy and eager to go back to sleep. I adjusted his covers and he went right back to sleep. He seldom asks me to stay up to help him go back to sleep anymore. On this occasion I put the light on, at his request, and returned to my room. His mood, almost always, is happy and normal.

Best,

BILL

BEVERLY HILLS CALIF

June 22, 1948

DEAR BILL AND LENORE,

I note Paul's continued improvement with great satisfaction. That you rarely have to stay up with him now even to help him go back to sleep. The dream about his losing you in the subway is still his concern about the same thing, to get rid of you (that little roué), but he can go back to sleep now with less need for reassurance and with less guilt. He was, as you said, too sleepy to want to hear anything about it, and it was fine to just let him go back to sleep. If he brought it up again later, you might have given him the same interpretations and reassurances as you did in the past on this phase of it.

The main point of this letter now, however, concerns the prospect of the one bedroom again for the family this summer.

What I have to say on this subject might already be to no avail, but I think it will be of help to at least let you know how I feel about it, so that you can be aware of it and ready for what may come. As I said in my last letter, I think it would be very unwise for you all to share one bedroom again and that every possible effort should be made for some other arrangement. He's a big boy now, and should really be spared the undue stimulation he will unavoidably get if he is in such close physical

proximity to your bed This is the thing he's been struggling with all year and now it would be like exposing him all over again

Perhaps the only alternative is the small kitchen you mention If you could get a cot and crib in there it should be done I think both children ought to be in one room by now instead of Anne with you Or is it at all possible because I think this is a must to obtain some extra room there or a porch or anything?

If it's out of the question then we'll just have to make the best of it In that event just use your discretion and judgment and try to maintain as much privacy for yourselves as possible

Otherwise the freedom and outdoor life of the country will no doubt be wonderful for all of you as well as for Paul Hope you have a pleasant summer

LEO

P S What I said about the bedroom applies just as well even when you Bill won't be there i.e. when he's alone with Lenore in the room It isn't the actual sounds that he might hear or what he may see but what he imagines and feels and thinks and fantasies in such a situation Another point is that while he may seem to be impervious to it and unaffected at the time effects of this could show up months later and in many devious ways (as it did in the past)

It seemed as if external conditions just were not going to remain ideal or favorable for healing Instead Paul seemed headed almost as if this were being experimentally controlled for a repetition of exposure to a traumatic and noxious stimulus This manner of summer vacation can have a pernicious effect at this particular point in a boy's life in several ways The alternating absence and presence of the father while the child remains with the mother represents an alternating unconscious fulfillment and denial of oedipal wishes a condition which opposes resolution of the complex This factor was present and played a similar role in the Little Hans case as will be noted below Moreover the physical arrangement in our case is such as to make repeated exposure to primal scene material inevitable we remember that this had already taken place the entire previous summer

As it turned out there was even a further complication the occurrence of a long confining physical illness It was after the summer when I heard again this time from Paul's mother

NEW YORK CITY
September 13 1948

DEAR LEO

I've asked Bill a few times to report on Paul's progress to you but he's just been too busy and tired so I'll try to give you some information

1) When we got to the country, I separated the bedroom by putting up a curtain on a drawstring and used it every night. Paul had improved completely at night, but made many remarks during the daytime which showed me that he hadn't gotten over his problem completely. I don't remember all of them but two typical thoughts would be: 1) What if Daddy should have an accident, or die, etc., before coming up? 2) On the subject of penes: how big Daddy's was and how big Grandpa's was, etc.

I felt, however, that things were going well until Paul became physically sick. He had a very bad time of it in the country, with the village doctor diagnosing it as bronchitis and he grew steadily worse for ten days until we had another doctor look at him. He told us Paul had virus pneumonia with one lung completely congested. He advised our going home, saying that recovery would be much quicker that way. We took Paul home the very same day. He lay in bed for another three weeks getting stuck with penicillin daily. No small wonder then that he reverted for a brief time to the old Paul with two changes. Whereas before he was quite willing to go to sleep but would have nightmares, now he would refuse altogether to go into his bedroom, would have an outburst of loud crying or yelling insisting that we stay in his room. This we refused to do, but kept talking to him and reassuring him about things in general. Also, at the same time, I was dismayed to notice that he got diarrhea and made a terrible fuss about cramps and going to the bath room. This also I'm tickled to say we cured after just a few days by my telling him repeatedly that it was nothing he ate, but some fear or feeling of guilt, or worry, etc. that was causing it. [An indication of a considerably changed and better attitude on the part of the mother, one which bodes well for Paul's future.] His tantrums at bedtime were also very short-lived; he makes no fuss and also sleeps through most nights. I realize now, however, that for Paul the whole idea of a summer away from Bill, with his only coming up for weekends is a bad one. He's lost a lot of weight and looks like a starved child, but I guess he'll pick up soon.

Anne is a happy, independent child, thank God. I've lost quite a few pounds waiting on Paul and gained a few grey hairs—but things are looking up again.

With all our best,
LENORE

Physical illness exerts an effect in several ways. On the one hand it depletes the ego, thereby weakening its defenses and causing regression on that account. In addition it naturally tends toward increased ministrations and direct attention from the mother, thus again intensifying the oedipal longings, encouraging fixation, and delaying the onset of the next, the latency period. Confinement in bed, moreover, in itself encourages autoerotic practices with their accompanying fantasies.

BEVERLY HILLS CALIF

October 23 1948

DEAR BILL AND LENORE

Our correspondence about Paul has sort of slowed down of late but of course for very good and welcome reasons i.e. that he was really so much improved and that there was therefore so much less to say about him. However I would like to make a few comments on your last letter.

1) It certainly is regrettable how that old virus had to come along and give you such a rough time. Now it isn't at all uncommon for an emotional problem like this one to regress i.e. go backward during any time of crisis or discomfort such as a physical illness imposes. Therefore it is not surprising that you write of the recurrence which took place both in the bedtime tantrums and in the bowel symptoms. However I was happy to note that both lasted only a few days and then disappeared. How good it is that you weren't thereby tricked again into dietary measures overprecautions and an oversolicitous attitude about the diarrhea. Your present attitude and explanations to him promptly removed the trouble. Try to work hard at keeping this up—it will pay dividends and strong benefits.

2) Some of the daytime comments of his which you quote reveal that he's still working at and adjusting to the same theme i.e. his being daddy's rival which always takes time to resolve and be disposed of. Perhaps it has obtained expression and come more into the open. Just try to retain now the open and understanding attitudes which you've both become so aware of during this whole experience. Let him express his thoughts freely and without fear—this is so healthy compared to keeping it within.

3) The curtain idea was a good compromise during the summer. From now on though I think he should have his own room always summer and winter i.e. separate from you. I guess Anne will of course have to be with him for a while—at least until your next living quarters.

Yours

LEO

A few days later, a message from the father added his version of this most recent period.

NEW YORK CITY
October 27 1948

DEAR LEO

About Paul. As Lenore already has written we returned from the country the first week in August with Paul badly ill. He remained in bed for about four weeks thereafter in our bedroom. [The mother had neglected to mention this fact in her letter! We must by now wonder whether the ease with which Paul keeps bobbing up in his parents

bedroom may not be an indication of a proclivity on the parents' part to bring this about, perhaps for unconscious reasons of their own] to keep him away from Anne Upon his getting well, he put up a little fuss about returning to his own room, and again showed signs of bad bowels—but this lasted for only a few days, we talked about it again, and he returned to his own bed in his own room without too much fuss Since that time things have been fairly smooth He sleeps well most nights, never asks to have one of us sleep with him, and in general behaves happily and normally Bowels O K. Nothing much to report in the way of dreams

Just this week, however, we were sharply reminded that the problem is still there Paul awoke the other night, fearful and unhappy, and Lenore had to sit on the living room couch (visible from Paul's bed) until he fell asleep In the morning after much questioning he admitted, with obvious guilt, that he had dreamed that "daddy was shot and killed by a cowboy" (He has been seeing a great many bad Western films on the television set of a friend) Two nights later, he awoke again In the morning he told us that he had dreamed that "daddy fell off the station and was killed by the train" On both these occasions it was difficult to get Paul to tell us the dream He was very, very guilty and afraid and unhappy I explained that dreams of this kind are not unnatural, that all little boys have them about their daddies in one way or another, and that I wasn't hurt or insulted or angry in any way—that he had nothing to fear in the way of punishment for these dreams and ought not to feel any guilt about them

In thinking about these dreams, I have thought that this is much better than last year's gorilla and wolf and fox dreams Less concealing symbolism more open reaction to the father rivalry . . . and I see in your letter that you agree

To Paul, however, I have said nothing this week about why he dreams these dreams—his obvious wish fulfillments *re me* I felt that such an explanation might increase his guilt, and make him more unhappy I simply let it go with assurances that I was not angry, that I understood and still loved him and that he ought not to feel guilty or afraid. What's your advice on this?

In school Paul is doing very well—happy, well adjusted and Phi Beta Kappa At home, he is always in search of activity, a game, a book, go visit friends, or have friends in his house Unfortunately, there are not enough nice kids his age on the block and he is often without some thing to do We hope to improve this situation soon by getting a piano and beginning his musical education He is very happy and excited and eager about this. So are we all Lenore will play again—and even I may take lessons if time permits

Just a few words about Anne She is the most charming delightful many-sided, enjoyable, lovable imp you ever did see And that's no exag

geration Lenore is well endorses everything I write in this letter
feels just the same way I do about things

Our best to you,
BILL AND LENORE

Should these last two reported dreams, of father being killed by a cowboy, or by the train, obvious father rivalry and death wish dreams, cause us surprise or disappointment at this point, and should they signalize, as they might at first glance, that we have been deluding ourselves about the existence of a therapeutic process until now? Are these residual dreams analogous to the discovery of malignant glands left behind after the supposed complete excision of a malignant mass—glands which potentially are as ominous and threatening as the original lesion itself? A bit of reflection will reveal the essential differences involved. In the emotional life, the appearance of death wish dreams in an isolated or occasional way are per se not at all incompatible with so-called complete normality. They are, as a matter of fact, healthy outlets for unacceptable wishes. Theodor Reik's aphorism, "A murderous dream a day keeps the psychiatrist away," derives from this.

The present situation is rather to be compared with Paul's previous state. The hostile, jealous conflict with the father is now in the open and undisguised. The father can appear as himself in the dreams and take his punishment; there is no longer a need to create a gorilla or fox or wolf nor to avoid them in nightly terror. Thus the character of the dreams now and then is qualitatively different, quantitatively too, with regard to frequency: these latest ones are isolated, sporadic, and occasional, while previously the nightmares occurred with methodical regularity, a ghostly form which was visible as soon as the lights were turned off.

The description given of his present general mood and total behavior is also an effective guidepost to the dynamic changes that have taken place. His generally happy and carefree state, his schoolwork, his physical and gastrointestinal health, speak as much as the change in the nightmares. The liberation of energy formerly bound in the internal neurotic conflict is also reflected now in the eager search for new activity, his need and readiness for new objects and new outlets.

With regard to the seemingly monotonous repetition of one theme, the wish to get rid of the father, Freud made the following remarks about the repetition of the same wish in the case of Little Hans: "We must not be surprised to find the same wishes constantly reappearing in the course of the analysis. The monotony only arises because the process of interpretation has been completed. For Hans they were not mere repetitions, but

steps in a progressive development from timid hinting to fully conscious, undistorted perspicuity."

The notes were now becoming further apart:

BEVERLY HILLS CALIF

December 25, 1948

DEAR BILL AND LENORE,

About Paul In your last note to us on October 27, he seemed quite well and relaxed You mention two dreams of father being killed Yes, I agree with you that there is less concealing symbolism and that this is a sign of the progress he has made There is a steady progressive development of his acceptance of this idea, from timid hinting at first to more and more real conscious acceptance and digestion of it You need do no more than you are doing, i.e., steady reassurance without necessarily repeating the interpretations which you have already made

I hope he is in his own room now for good I think that even with such provocations as the pneumonia, you ought from now on to do some thing other than to bring him back to your room

He seems to be doing fine now as far as sleep school bowels etc are concerned His search for new activities is a healthy search for new outlets and sublimations I hear you already have acquired the piano—how is Paul taking to it?

What is the latest on him? I have a feeling that now this is all becoming a thing of the past I'd appreciate a note about him, even if (and this is best), it's a negative one

LEO

The next reply can be considered to mark a satisfactory conclusion to this episode in Paul's life

NEW YORK CITY

February 8, 1949

DEAR LEO,

The newest thing in our house is our baby grand piano which has proved to be the happiest investment I've ever made It has added an additional warmth and joy to the household for all of us Paul has taken to his lessons like the proverbial duck to water His teacher, confirming Carl's opinion [a maternal uncle, a talented musician] finds him the most musical kid she's ever met He absorbs the stuff with ease practices daily and likes it (so far) and performs before any and all visitors at the drop of a hat The piano besides school and other outside interests has provided Paul with stimulating engrossing activities, resulting in a tremendous improvement in his total personality—sleep is fine, rarely troubled, bowels O.K. for as long as we can remember, doing excellently

in school (outstanding student) and no discussion at all any more about his former difficulties

With all our best,

As ever,

BILL, LENORE PAUL AND ANNE

Only with a proper resolution of the oedipal conflict can instinctual energy really be freed to move on into new directions in the path of emotional development. The vigor with which Paul is now able and eager to follow his natural musical bent and other activities is related to and a sequel of this newly liberated libidinal energy.

Comparison with 'Little Hans' case There are a number of very striking parallels and similarities in occurrences and background events between this case and Freud's famous Little Hans patient, likenesses which I believe are of more than coincidental significance. First, both were phobics, though Hans' phobia existed all day, while Paul's was more circumscribed, being limited to the specific conditions which prevail during sleep. This is in essence only a quantitative difference. Paul was able to repress the pathogenic conflict during the dynamic conditions of waking life (though to be sure it broke through and showed itself in some ways, e.g., the bowel symptoms, general mood, attitude toward school etc.) but in bed at night conditions changed. The shift of balance in favor of instincts, which occurs then, made other defenses necessary. The dream then attempted to bind together the erupting forces. It failed and anxiety broke through. Phobia was the next step, a phobia directed against the very product of the dream work, the dream itself and its contents. Later the phobia was directed against the conditions under which the dream would appear, the state of going to sleep.

In both cases the onset of symptoms occurred at exactly the same age, at four and three quarter years. Both children selected animals as their objects of fear, one the horses of real life, the other the jungle animals of his dream life. The same role is played in both cases by summer vacations and their influences. We recall Hans' summer holidays at Gmunden and the part they played in the unfolding of his story: the intimate closeness there with the mother, while the father was an irregular visitor. The same situation held true in our case. Moreover, in both instances effects did not appear until the return to the city.

Both children can be described as being of superior intelligence, precocious, sensitive, and imaginative. A crucial occurrence to each was the birth of a little sister, to Hans at three and a half to Paul at four and a half. Not only does this event accentuate and threaten the relationship with the parents, but at the same time, as Freud points out, it revives

memory traces of the child's earliest pleasure experiences, and also in itself causes an outburst of sexual pleasure and curiosity. Physical illness ensued during the course of each treatment, "influenza" in Hans and virus pneumonia in Paul, and each, by the same mechanisms, described above, produced exacerbation of the phobic symptoms

In each treatment, a most powerful resistance was early removed, and a major impetus given to the ready flow of unconscious material, by prompt enlightenment and interpretation on the subject of jealous and hostile wishes against the father. In both cases, anxiety symptoms are described as existing in the mother, and the dominant role in treatment is spontaneously taken by the father. Both sets of parents are affectionate, permissive and enlightened in their approach to the children. Strikingly, even the specific sublimation outlets seem to coincide. Freud remarks on Hans' increased interest in music and the development of his inherited musical gift. The very same is now taking place with Paul.

While some of these parallels must no doubt be fortuitous, the general conformity between the two cases must, I believe, lie in the fact that the neuroses of childhood, in contrast to those of adults, are rooted more in universal experiences than in specific individual determinants. This must be more and more true the further back we go, so that the closer we approach the most primitive, original and least differentiated state, the more does the anxiety producing stimulus become universal, as ultimately, for example, the birth trauma. That these two cases show such strongly similar trends and events stems from identities in the psychodynamic backgrounds and in the family constellations and attitudes. This would tend to bear out the words with which Freud concludes the Hans case, claiming for it the significance 'of being a type and a model,' and supposing that 'the multiplicity of the phenomena of repression exhibited by neuroses do not prevent their being derived from a very limited number of processes concerned with identical ideational complexes.'

Some remarks on transference and the upbringing and education of children. I would like to make some remarks about the situation as it was in this case, with the father himself being the one to directly conduct the therapeutic situation rather than, as is usually the case, the intervening analyst. The transference situation, even in the usual setting of child analysis, is different from that in adult analysis, in that at best the analyst can only in part become the object upon whom the instinctual emotional energies center. This stems from the fact that the original determining figures, i.e., the parents, are still very actively in the picture and the original formative and crucial object relationships are still fluid and not yet solidified. Although this prevents the formation of a typical transference neurosis in child analysis, nevertheless, it is the introduction of a new

and different object into the picture—namely, the analyst—which modifies, reverses and rechannelizes the distortions and fixations and displacements which have occurred and are still taking place in the course of instinctual development. At the end of this analytic relationship, the problem always has to be faced of then handing back the now modified and altered child to the very environment in which the traumata responsible for the illness originally took place. It is hoped, of course, and it is one of the necessary goals of treatment, that in the meantime certain changes have also taken place in the central figures of this environment—changes which will thereafter move them in the same direction and along the same current as the analytic process has guided the patient. This often remains as one of the main vexations and drawbacks impeding the end result of child analysis.

In the case here reported, however, as with 'Little Hans' and in several other reported instances, the situation is different in that it is the parent himself who confronts the neurotic process in the child and endeavors to encourage changes. The reversal of the pathologic process and the re-directing of instinctual energy does not take place via the intervention of a new object, with a new type of relationship which is then transferred back to the parents, but rather by a direct alteration in the attitudes and responses of the very persons who provoked the original repression and displacements. The child is subjected to a new and therapeutic experience in living within the familiar arena of his own life, "*in situ*" so to speak, or "*in vivo*," rather than to a comparatively artificial and laboratory-like analytic relationship. This is to be sure, more difficult to achieve in a case in which a neurotic symptom has become fully formed, than it is in the milder and more transient emotional problems of childhood, where the direct enlightenment of the parents is frequently sufficient to produce the desired result. This is no doubt akin to what ordinarily and commonly must take place in the normal transient fears, anxieties and phobias of childhood, as these spontaneously dissipate and resolve themselves in response to the proper word or attitude on the part of the loving and understanding parent. Barrett recorded two such cases, a little boy and a little girl, in whom transient anxieties and the course of their resolution could be clearly traced in their relation to parental reassurance and explanations. Grotjahn described parental observations on the dreams of a two-year four month old baby and their relation to the transient emotions and anxieties of the previous day. A case reported by Kubie shows how a traffic phobia in a six year old boy cleared up in response to conversations between the father and son.

When the parents acquire new insight and initiate therapeutic alterations and these then radiate secondarily toward the child, the next prob-

lematic step is avoided—that of having the child return for continuing educative influences to a still uncertain environment. Moreover, the way is now open for healthier identifications and for a more reasonable superego formation. The still incompletely developed superego, which in its development had begun to show a tendency to excessive demands, is in this case favorably influenced from within. It is not altered by new ingredients added from without, but rather by changing and improving the very ingredients which go to make it up during the process of its being built. When it can be done, this particular way, it seems to me, should have advantages for the child. To insure proper upbringing in *statu nascendi* is preferable to letting the structure go up and then having to recondition it afterwards by analysis.

Some further comments. There are a number of thoughts and questions arising from this case which are worthy of some further remarks and clarification. Some of these were raised at an analytic seminar at which this case was presented, and might serve as a focus for this part of the discussion. One of these issues, for example, is the fact that a number of obviously important topics never came up for discussion and were therefore never interpreted in the interchange between father and son. What about the role of masturbation, for example, which without doubt must have played a large part in bringing on the nocturnal anxiety? This was conspicuously absent in the material: neither was there any specific discussion of anal and other conflicts. Of course, much could be pointed to which did not come up. Paul has not been analyzed. The purpose of the therapy was the application of as much analytic thinking as possible under the limitations imposed, for the understanding and the alleviation of the symptoms. This was achieved, it seems to me, not by an uncovering and making conscious and acceptable all the ramifications of the specific pathogenic conflicts, but rather by the therapeutic emotional experience which Paul underwent in his relationship with his parents. This experience favorably altered the dynamic equilibrium between his instinctual forces on the one hand and on the other the forces of the external world and his nascent and young superego. The prohibiting strength and power of the latter was weakened, first by a new evaluation of and actual change in the nature of the externally threatening castrating figures (parents), and then automatically by a similar change in their internalized representatives within the superego. Instinctual impulses, such as masturbation with its accompanying oedipal fantasies, could then be more easily and adequately handled.

There are also objections from the opposite direction. Certain people still express reactions of doubt and ambivalence to the basic idea of an approach such as taken in this case, reactions still much the same as those

which greeted the 'Little Hans' case and which were countered by Freud forty years ago. Thus since they probably will be duplicated by some readers, we will mention a few minority comments which ran as follows. "All children," it was said, 'have nightmares at one time or other, most often these go away by themselves and need no treatment. We should think carefully before interfering with them.' Or even more strongly, 'Intervention of this sort only serves to stir up and keep active childhood complexes which should be allowed to become dormant and to be resolved by the natural course of growth and development.' In reply, it would be well to refer back to the original two letters, in order to recall the pitiful suffering to which Paul was subjected, its intensity, duration, and specific character. Furthermore, all people know what fear is. Yet fears can become phobias of such magnitude as to make intervention not only desirable, but the only humane thing to do. Moreover, symptoms can disappear in different ways, for different reasons, and with different results. A symptom can be frightened or browbeaten away, by either direct or subtle means, but always at high cost to the total character, which pays the price thereafter of having to devote a good portion of its available energy to the forces of repression, with resultant crippling and limitation of the total personality. Or a nucleus is created which later in life can then be reactivated by a trivial stimulus with the formation of full blown symptoms.

The situation, however, is quite different when, as in this case, the symptom is removed not by increased repression, but rather by undoing the process of repression and replacing it with a) in part renunciation of instinctual wishes (as the oedipal wish) b) partial gratification of instincts (as masturbation impulses), and c) in part discharge through sublimated activity. Far from stirring up and activating pathological complexes and preventing their proper resolution, this process actually tends to prevent and remedy the visible beginnings of maldevelopments in the line of emotional growth. It goes without saying that when the normal course of growth and development is leading to happy results, all this is superfluous.

Finally, and again using as a guide the discussion which this case provoked, it would be well to reaffirm the obvious dangers involved and the need for caution with regard to the method, long distance correspondence, which of necessity had to be used in this particular clinical instance. It is indeed the rare situation in which circumstances would all conspire, as in this case, to make this even feasible, utter confidence in the parents and thorough familiarity with the local conditions were indispensable prerequisites. In the more usual situations which we meet in our everyday practices, it would be unthinkable to consider carrying on through this thin and insecure line of contact.

August, 1950 Paul has remained symptom free

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THE MOTHER AS THERAPIST, IN A CASE OF OBSESSIONAL NEUROSIS

By AUGUSTA BONNARD (London)¹

This is a description of the case of a boy of four and a half years suffering from a fairly severe obsessional state. It has been selected because it presents interesting features from the technical, theoretical and clinical points of view. Although the mode of treatment was not one of choice but arose out of necessity, yet the results are so good that it invites consideration in its own right.

Unlike the majority of mothers who attend child guidance clinics this child's mother was free of any marked neurotic disturbance. For these reasons, and because there was no early vacancy on our treatment waiting list, it was decided to use her as a therapeutic intermediary between myself and her son. The work was conducted at the East London Child Guidance Clinic. Since the War, it has been reopened as a department of a hospital, namely the London Jewish. As all hospitals are now the property of the State, this case chances to be the first recorded of nationally provided psychoanalytic therapy. Our Clinic's psychiatric and therapeutic personnel is all psychoanalytically trained, and it is still the only hospital staff to be so. In contradistinction there are a few other child guidance clinics which are psychoanalytically orientated, but they do not form part of the medical services of a general hospital. Among these are the three clinics founded by the late Dr. Kate Friedlander.

The type of work described in this article is atypical for our clinic, since most of the suitable cases receive treatment at the hands of the therapists. This is either of an intensive or short nature, i.e. four or else one session weekly, depending on the circumstances. It is also customary with us for the same therapist to interview the mother of the child as often as she considers necessary. Owing to the pressure of clinic work it was not normally possible to see this mother more often than fortnightly, except during crisis phases of the treatment, when she was seen weekly. During the period of one and three-quarter years of the treatment (which still continues) there were three major breaks: one due to consecutive measles infection, first of the little boy and then of his sister, and two periods (one of them lasting nearly two months) when the mother herself

¹ Psychiatrist in charge of the East London Child Guidance Clinic.

was twice admitted to the hospital as a patient, the second time in order to undergo an operation. Nevertheless the material was so rich, detailed and classical in its evolution, that it has proved necessary to compress it within the compass of the child's "leading" ideas and of certain over-determined but typical behavior.

Justifiable doubt might be expressed that this case was either not in the nature of a fully evolved obsessional neurosis, or, if it were, that it could not be cured by such infrequent treatment. However, as will be seen, there are certain factors which go far both to explain how this little boy came to fall ill, and why it nevertheless proved possible for his own mother to treat him.

SPECIAL CLINICAL CONSIDERATIONS

The first clinical consideration is that Robert's breakdown seems to have been precipitated by the weight of external circumstances, of which the most important was the traumatically extreme behavior of his other sibling, namely his sister Beatrice, two years and two months his junior. Later on, as more was known of the environment, it was realized that her violent reactions were characteristic of all the father's family, several of whom lived next door. It will also be seen that Robert's father presented psychic abnormalities, some of which were to become recognizably paranoiac as his son's treatment advanced. These paternal character changes came to react unfavorably on the boy, but at a stage in the work when they could no longer contribute pathogenic elements to the child's neurosis. Robert's hostility had fortunately still continued to be centered on these exceptional stimuli. His ambivalence was therefore split, and thus it remained possible for his mother, during the critical introductory phase of his analysis, to remain sufficiently immune from his aggression to allow him to accept her interpretations. Later on when she, too, came within the sphere of his ambivalent reactions, both mother and son had sufficient knowledge and insight to be able to grasp the irrational significance of his behavior, and both were therefore able to continue to work out its meaning.

This favorable course of clinical events also permitted the development of a variety of sublimatory outlets which he used, in a secondary way, sometimes consciously, in order to lessen the tension of his conflicts and of his anxiety.

ANTECEDENTS AND ENVIRONMENTAL BACKGROUNDS

Robert's mother first came to our department on the recommendation of the Out-Patient Sister. She arrived in a harassed, frantic state, with her twenty-

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